Community Action Commissions of Belmont County, Head Start Program
153 West Main Street · St. Clairsville, Ohio 43950
Phone: 740-695-0293 extension 5 · FAX 740-695-0869

Release of Information to Head Start

I hereby give my permission to: _____
(Agency/physician)

_____
(Address) (City/State) (Fax)

To release all information to Belmont County Head Start concerning my child for the purpose of providing care and educational programming beneficial to my child while in Head Start. This information will not be shared with any other Agency/Organization. This release expires one (1) year from date signed. Parent/Guardian may revoke this release, within the one (1) year expiration date, except to the extent it has previously been acted upon.

Area of Concern _____

Diagnostic Report Service Plans (OT, PT, Speech) Behavior Plans

Prescribed Medications Individual Education Plan Lab Results (Lead, hct/hgb)

Immunization Record Other: _____

This section to be completed by Physician/Medical Professional

Diagnosis: _____ Medications: _____

Recommendations/Limitations for this child: _____

Physician Signature: _____ Date: _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

_____ _____
Date Parent/Guardian Signature

_____ _____
Date Head Start Staff Signature