

**WVCAC Head Start
Parent Permission and Referral Form**

Child's Name: _____ **DOB:** _____ **SS#:** _____

Center: _____ **Classroom:** _____ **Teacher:** _____

Parent/Guardian Name: _____ **Phone:** _____

Address: _____ **City:** _____ **Zip:** _____

Concerns: _____

Screening Information:

Brigance Head Start Screen: Date: _____ Score: _____ Concerns: _____

Medical Concerns: (See Medical History) _____

Vision Exam: Date: _____ Results: _____ Concerns: _____

Hearing Exam: Date: _____ Results: _____ Concerns: _____

This is to confirm that my child's teacher and/or Special Services Manager have consulted with me regarding an evaluation to determine the most appropriate educational services for my child. As the parent/guardian I give consent for Washita Valley CAC Head Start to share information with the following service provider and to proceed with the following evaluation. This referral will be valid throughout my child's enrollment in Head Start.

Evaluation: _____ **Referred To:** _____

Insurance: _____ **Policy Number:** _____

Parent/ Guardian Signature: _____ **Date:** _____

Special Services Manager Signature: _____ **Date:** _____

This is to confirm that at this time I choose to decline the referral for evaluation. I will notify the Special Services Manager if there is a change in my decision.

Parent/Guardian Signature: _____ **Date:** _____

Special Services Manager Signature: _____ **Date:** _____

Follow-Up: _____

205 W. Chickasha Ave. Suite 5
Chickasha, OK 73018
(405)224-5831 Ext. 127

White- Service Provider

Yellow- Child's Folder

Pink- Special Services Manager