SOUTH CENTRAL CHILD DEVELOPMENT INC.
RELEASE OF INFORMATION-PERMISSIONS-CONSENTS

Child name:_____________________________________ Family name:________________________________

Center:_________________________________ Child's DOB: ___________________________________

	Please Initial YES	NO
1. **Release of Information:** I give consent for my child's primary health care providers (Doctor, dentist, specialist,) county health nurses, WIC program, public preschool to send all information pertaining to the immunization, health, dental, mental health services and educational records of my child to South Central Child Development Inc., 401 Walnut Avenue, Wagner SD 57380. **Physician/Clinic** ______________________________ **Phone #** ____________ **Dentist/Clinic** ______________________________ **Phone #** ____________ **WIC Office** ______________________________ **Phone #** ____________ **Educational COOP/School** ______________________ **Phone #** ____________ **Mental Health Provider** ______________________ **Phone #** ____________		
2. **Head Start Screening:** I give permission for my child to participate in all screenings provided by SCCD Inc. staff and/or other professionals which may include vision, hearing/tympanograms, speech/language, height/weight, blood pressure, hemoglobin, dental, blood lead screening, nutritional assessment, mental health consultation and developmental screening.		
3. **Health/Education Records:** I give permission for my child's health, dental, immunization and transition records to be forwarded to the public, parochial school at the completion of the school year.		
4. **Publicity:** I give consent and approval to SCCD Inc to publish and distribute both my child's name and photograph, which is property of SCCD Inc, for the purpose of informing the public of the activities of SCCD Inc.		
5. **Transportation:** Transportation will be provided for Head Start children if pick-up and drop-off are within the designated bus routes. For families living outside the designated bus routes, it is the parent(s)/guardian(s) responsibility to get their child(ren) to the center or to a pick-up and drop-off locations within the designated bus routes. It will be the parent's/guardian's responsibility to walk their child to and from the bus. By signing, the parent(s)/guardian(s) is in agreement to the above statement.		

Bus Route Pick-up Location and Phone Number ____
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Bus Route Drop-Off Location and Phone Number ____
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6. **First Aid/CPR:** I understand that SCCD Inc. staff will administer emergency medical care (First Aid or CPR) when necessary.	X

Parental consent: "Consent" means that the parent(s) / guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language or other mode of communication. The parent(s) / guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought and the consent describes the activity and records which will be obtained or released and the granting of consent by the parent(s) / guardian(s) is voluntary and may be revoked in writing at any time.

____ ______________
Authorized Signature of Parent or Legal Guardian **Date**

Note: A photocopy of this release shall be as valid as the original. This release is valid until revoked by Parent/Guardian, but no longer than one year.

White: Area Manager/Office copy
Canary: Teacher file copy
Pink: Parent copy