

SUU Head Start Parent Waiver for Medical/ Dental Treatment

I, _____, am the primary caregiver of _____. I have been notified and understand that my child is out of compliance with SUU Head Start concerning the Child Health and Safety Plan. I give permission for SUU Head Start staff to accompany me and my child to accomplish the following:

- Medical Exam
- Dental Exam
- Medical Follow-up
- Dental Follow-up
- Immunizations

If a situation arises that would put other Head Start children at risk (i.e. outbreak of an immunized disease) it is understood that SUU Head Start employees and medical personnel will make the necessary attempts to contact me or an authorized "Person to Contact". I consent to allow SUU Head Start staff to accompany my child to needed treatment and agree that Southern Utah University and Head Start directors and employees shall not be, nor later become liable or responsible in any way in conjunction with services provided.

Parent/Guardian's Signature

Date

Witness Signature

Date

Witness Signature

Date

Person to Contact

Name Relationship Phone number

Name Relationship Phone number