



Child's Name: _____ Center: _____
Parent/Guardians: _____ Telephone: _____

As marked below, barriers to my Head Start child's health care participation have been identified, addressed, and (where possible) removed:

- 1) Transportation to doctor's office/clinic, dentist office, health department, etc.
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
- 2) Care of other children while parents take enrolled child for medical or dental care visits.
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
- 3) Scheduling of date or time of the dentist/doctor appointment.
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
- 4) Cost of care or co-pays for medical and/or dental care.
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
- 5) Release of medical, dental or other relevant records from other agencies.
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
- 6) Other: _____
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____

Parent/Guardian: _____ Date: _____

Family Advocate: _____ Date: _____

Health Services Manager: _____ Date: _____

Head Start

351 W. Center
Cedar City, Utah 84720
(435) 586-6070
Toll free 1-800-796-6070
Fax 1-435-586-5232



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I have reviewed the barriers that have prevented me from obtaining health care for my child with my Family Advocate and/or the Health Services Manager. These barriers have been addressed to the best of the SUU Head Start program abilities.

I understand that participation in the SUU Head Start program is voluntary and my choice to get health/dental care for my child does not affect my child's enrollment.

As parent/guardian for the Head Start child above, I will seek health/dental care for my Head Start child within 2 weeks from today's date.

Parent Initials

Date of next appointment with the Family Advocate: _____

As parent or guardian of the Head Start child listed above, I do not give authorization for my child to receive health and/ or dental examinations or follow up care.

Parent Initials

Parent Comments:

Parent/Guardian: _____ Date: _____

Family Advocate: _____ Date: _____

Health Services Manager: _____ Date: _____