

Community Action Team, Inc.
CHILD & FAMILY DEVELOPMENT PROGRAMS

Parent Permission for Mental Health Observation and Classroom Planning

CHILD: _____ DATE OF BIRTH: _____ CENTER/CLASS: _____

After getting to know your child in a classroom setting, it would be helpful to have our mental health consultant observe your child at Head Start to ensure that we provide the best learning environment while supporting you and your child.

If you give your permission, your child will be observed and the mental health consultant will share the information with you and Head Start. This will enable us to develop the best learning plan for your child.

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- I **DO** give my permission to have my child evaluated and for the information to be shared with Head Start.

Parent/Guardian Signature Date

- I **DO NOT** give my permission to have my child evaluated or for the information to be shared with Head Start.

Parent/Guardian Signature Date

Signature of Staff Person Obtaining Permission / Date