State of Illinois
Department of Human Services - Migrant & Seasonal Head Start

PARENT/GUARDIAN CONSENT FOR TREATMENT, DIAGNOSIS, AND OTHER MEDICAL SERVICES

I understand that my child, _____

(Name of Child)

needs to receive from _____

(Name of Service Provider)

The following specific services:

_____

_____

_____

_____

☐ I give consent for the services described above

☐ I DO NOT give consent for the services named above

My consent for these services expires _____

_____ _____

(Signature of Parent or Guardian) (Date)

I explained the purpose of this consent to _____

(Name of Parent or Guardian)

before it was signed.

_____ _____

(Signature of Head Start Representative) (Date)

Complete this form as needed before medical treatment services are provided. No services may be performed before parent signature.