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

PARENT NOTIFICATION OF MEDICAL/DENTAL RE-SCREENING, EVALUATION OR TREATMENT RESULTS

Child's Name: _____

1. _____ **Your child has been re-screened for:** _____

_____

and the results are: _____

_____

Comments, (if any): _____

2. _____ **Your child has been evaluated for:** _____

_____

and the results are: _____

_____

Comments (if any): _____

3. _____ **Your child has completed treatment for:** _____

_____

Comments (if any): _____

_____

_____ _____

Signature of Head Start Staff **Date**

Complete and send to parents within 3 days of each procedure or when results are received