Mental Health Observation Form

Center: ____________________________

Child: ____________________________

I, ____________________________________________, give my permission to
Parent/Guardian

the Mental Health provider, ____________________________________________,
to observe my child in the Head Start Center.

The Mental Health Provider will have access to all screening, medical and LAP-D
information. The center visit and observation will be discussed with the parent and staff.

The records are confidential and will be kept in a locked cabinet.

_________________________________                      _____________________
Parent’s Signature          Date

_________________________________                      _____________________
Head Start Representative          Date