Alachua County Public Schools
Early Intervention Services
Head Start/VPK

DENIAL OF CONSENT FOR HEALTH TREATMENT

As parent or legal guardian of _____
Child's Name

it is my desire that no (medical) (Dental) (Nutritional) treatment be provided to my child by the Head Start program. I understand that this treatment has been recommended and that it will be provided without cost to me. I accept the consequences of this action and in no way hold Head Start responsible for any future health problems resulting from the lack of the recommended treatment.

Date: _____ _____
Signature of Parent or Legal Guardian

Witnessed by:

Date: _____ _____
Signature of Witness

Center: _____

Reason for Denial: _____