MID-DELTA HEAD START
DENIAL OF MEDICAL AND/OR DENTAL SERVICES

I, _______________________, deny the following service or treatments for ______________________:  
Parent/Guardian: _______________________, Child’s Name: _______________________

DENTAL:

Type of treatment: ________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

MEDICAL:

Type of treatment: ________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

I understand that the services or treatments have been recommended as necessary or advisable for this child. I understand the type of services or treatments to be given.

Reason for refusal: ________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Signature of Parent/Guardian: _______________________________________________________

Relationship to child: _______________________, Witness: _______________________

I have explained to _______________________, the services or treatments recommended.

Signature of Head Start Staff: _______________________, Date: _______________________

To be completed by Teacher
Original filed in folder
Copy forwarded to Health Specialist