Community Action Partnership LEADS
HELP THAT LEADS YOU IN THE RIGHT DIRECTION

Community Authorization

Applicant's Name: Katerina Brewer

Date of Birth: 9/7/2014

I give permission for LEADS to contact the provider(s) listed below and authorize them to release information to maintain the applicant's records.

Physician/Pediatrician	Dentist	OB/GYN	WIC
Health Department	Audiologist/ENT	Optometrist	Foster Care Agency
LEA/School District	Child Support Agency	Dept. Job/Family Serv.	Social Security Admin.
Other			

Signature Stacy Brewer **Date** 10/10/18

Office Use Only:

Provider: _____

Documents Requested: _____

_____

Return to the Attention of: Chelsea Payne, Family Service Worker
LEADS Head Start/Early Head Start
10920 Mill Dam Rd. P. O Box 105
Phone: (740) 928-1123 Fax: (740) 928-1603

Thank you for your assistance in this matter. We hope to receive your response in a timely manner.

Community Action LEADS
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LEADS Program Authorization

Applicant Name: Katerina Brewer DOB: 9/7/204 Center: Buckeye Lake

Please read and "*initial*" each line for Yes or No

1. I give my consent to have my child's picture used for publication
   (Agency/Center Newsletters, Reports to community, Agency/center website, Local newspaper)
   Yes SB No_____

2. I give my consent to have my child's picture used for classroom/teacher use.
   Yes SB No_____

3. I give my consent for my child to be included in video used by the teacher and mentor only to evaluate teaching strategies.
   Yes SB No_____

4. I give my permission for my child to receive First-Aid by LEADS staff
   Yes SB No_____

5. By initialing, I am agreeing that my child may receive the following screenings: SB

Height & Weight Screening	Speech & Language Screening
Vision Screening	Developmental Screening
Hearing Screening	Social/Emotional Screening

This consent form is valid for one program year, expiring on August 31, 2019. Consent may be changed at any time by contacting your FSW.

Parent/Guardian Signature Stacy Brewer Date 10/10/18