Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

REFUSAL OF SERVICES

As the parent or legal guardian of _____, who attends _____Head Start or Early Head Start Program during the _____program year, it is my desire that no special services, treatments, or tests such as _____ be provided to my child by Head Start/Early Head Start staff or other contracted agency (_____). I know what the test, treatment or evaluation entails and it is part of the Head Start/Early Head Start Program.

I understand that treatment has been recommended and would be provided free-of-charge. I accept the consequences of this action and in no way hold the Head Start/Early Head Start Program or its contractual agencies responsible for any future problems resulting from refusal of treatment.

Parent/Guardian Signature: _____ _____ Date

Parent/Guardian Name: (Print) _____

Address: _____

Phone Number: _____

Witnessed by: _____ _____ Date

CC: Parent/Guardian
Child's File (Original)