Date Faxed ____________

HT-0015

Northwestern Ohio
COMMUNITY ACTION
Commission

1933 E Second Street
Defiance OH 43512
Phone: 419 784-2150
Fax: 419 782-5648

RECIPROCAL RELEASE OF INFORMATION

Child's Name: ______________________________ DOB: ____________

Child's Address: ______________________________

Child's Social Security Number: ______________________________

Parent/Legal Guardian's Name: ______________________________

I, the parent/legal guardian of ______________________________ hereby authorize ______________________________
(releasing agency name and address)

to release the below information concerning my child to: ______________________________

____
(receiving agency)

The information to be released consists of:

___educational records, evaluation results

___evaluations & services for hearing/vision screens *(circle one)*

___dental exam & treatments *(circle one)*

___mental health services, progress notes, diagnosis, treatment plan, evaluation results

___IEP/MFE/IFSP forms

___developmental (evaluations) results, diagnosis, and progress notes

___hematocrit/hemoglobin results

___medical information (exam & treatments) *(circle one)*

___allergy treatment recommendations

___asthma treatment recommendations

___lead screen results

___other (be specific)____________

____

This information will be used to assist in determining future education plans and special needs for my child. I understand that the information is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that the releasing agency cannot control the recipient's use of the information.

Parent Signature ______________________________ Date ____________

Witness Signature ______________________________ Date ____________

This consent form expires the final day of the current school/program year from the date of parent/ legal guardian's signature unless revoked by me in writing.

Please send information to: **Attn:** ____________________ (NOCAC Staff Person)
NOCAC Child Development/Head Start
1933 E. Second Street, Defiance, OH 43512

NOCAC CHILD DEVELOPMENT PROGRAMS
Head Start
Hearing Report Form

Dear parent – take this form to your doctor. Your child has failed our screen and needs professional evaluation by this date: ______________________. Ask your child's teacher if you do not know where to take him or her. Thank you!

Dear Provider – please complete this form and mail it to us as soon as possible after you see the child. Our federal regulations require that we document the visit. We appreciate your help!

Child's Name	Date of Referral:
Center	**D.O.B.**
Reason For Referral (screening failed or type of symptom):	

Pure Tone Audiogram Results:
Right Ear______ db   Left Ear______db

Was treatment for a hearing problem necessary for this child?   yes_____   no_____
If yes, please attach a copy of the report.

Did you initiate this treatment?   yes_____   no_____

Do you wish to see this child again?   yes____   no____   When__________________

Summary of hearing problem and diagnosis, if indicated:
Comments:

Specialist Signature:	**Return form to:** Disabilities/Intervention Coordinator 1933 E. Second St. Defiance, Oh. 43512
Address;	
Date:	

White – Parent   Yellow – CO File

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NOCAC CHILD DEVELOPMENT PROGRAMS

Head Start
Vision Report Form

Dear parent – take this form to your doctor. Your child has failed our screen and needs professional evaluation by this date: ______________________________. Ask your child's teacher if you do not know where to take him or her. Thank you!

Dear Provider – please complete this form and mail it to us as soon as possible after you see the child. Our federal regulations require that we document the visit. We appreciate your help!

Child' s name	Date of Referral
Center	
Reason for Referral (screening failed or type of symptom):	

Eye Specialist Section

Visual Acuity

without glasses R______________ L______________ B______________

with glasses R______________ L______________ B______________

Summary of vision problems

Recommendation

Recommendation for Teacher

Additional treatment necessary?
_____ yes _____no

I wish to see the child again
_____ yes _____ no When ______________

Comments

Specialist Signature:	**Return form to:**
Address	Disabilities/Intervention Coordinator 1933 E. Second Street Defiance, Oh. 43512
Date of Service	

White – Parent Yellow – CO File

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