

# Tri-County Head Start/Early Head Start

## Permission Mental Health Observation

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_, to be observed by Tri-County Head Start/Early Head Start's mental health consultant. I understand that the results of the observation will be discussed with me and that the recommendations for my child will be considered and respected.

The purpose of these observations is not to diagnose, but to offer support to the child, family, and staff. These observations may result in recommendations for referrals to other agencies to ensure the child is receiving the appropriate support.

Please answer the following questions for the mental health professional.

1. Do you have concerns about your child's development?
  
  
  
  
  
  
  
  
  
  
2. Do you have concerns about your child's behavior?
  
  
  
  
  
  
  
  
  
  
3. Is there anything happening in your child's environment that you believe may have an impact on the concerns you list?

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date