DEQUEEN-MENA EDUCATIONAL COOPERATIVE

EALRY CHILDHOOD (3-5) PROJECT

SCREENING CONSENT

Name of Child: ______________________________ Date: __________

Birth Date: ____________ Age: __________ Race: ____________________

Social Security Number Required: ______________________________

Name of Parent/Guardian: ______________________________

Address: ______________________________ Phone: ____________________

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I give the DeQueen-Mena Educational Cooperative permission to complete the following areas of screening on my child:

Development	(X)
Speech/Language	(X)
Hearing	(X)
Vision	(X)

Special Concerns: ______________________________

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Has your child been evaluated for special services by any other agency? __________

If so, whom? ______________________________

Does you child have a Medicaid / AR KIDS card? ____________________

Medicaid Number: ______________________________

______________________________ ______________________________

Parent/Guardian Signature Date