# Highland Rim Head Start
# SOCIAL/EMOTIONAL
# PARENT – TEACHER REFERRAL

In order to ensure that every child is healthy physically and emotionally, Highland Rim Head Start contracts with a mental health professional to provide observations and appropriate recommendations regarding a child's behavior and emotional well-being. By signing this form, you acknowledge that your child may be exhibiting undesired behavior(s) either at home or at Head Start, and give the Highland Rim Head Start Health and Disability Manager and the Mental Health Consultant permission to observe your child in the classroom and individually if necessary. Please indicate in the space below why you feel a mental health referral is needed at this time.

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|---|---|
| **NAME OF CHILD** | **CENTER/CLASSROOM** |
| **DATE OF BIRTH** | **MAILING ADDRESS** |
| **PRINTED NAME OF PARENT/GUARDIAN** | **PHONE NUMBER:** |

**COMMENTS:** _____

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□ Yes, I give my permission to Highland Rim Head Start to refer my child for individual and classroom observation by the Mental Health Consultant.

□ No, I do not give my permission to Highland Rim Head Start to refer my child for individual and classroom observation by the Mental Health Consultant.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

HEAD START TEACHER SIGNATURE DATE