



Sarah Kuhlemeier  
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## Permission to Screen

\_\_\_\_\_  
Child's First Name

\_\_\_\_\_  
Child's Last Name

I, the parent or guardian of the above named child, give my permission for this child to participate in a developmental screening.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

I, the parent or guardian of the above named child, give consent to the screening agency to release information to the local early childhood programs for referral purposes and to the Stephenson County Health department for data collection only.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date