



Miami-Dade County
 Community Action and Human Services Department
Head Start/Early Head Start Division



Parental Consent for Early Childhood Mental Health Consultation Services
 (See Parent Information on Other Side)

The Community Action and Human Services Department (CAHSD) Head Start/Early Head Start program will provide early childhood mental health consultation services to all children who are enrolled in the program. The program uses the CSEFEL Teaching Pyramid Model for Positive Behavior Support which promotes children’s overall healthy social/emotional development, prevents mental health issues in young children and meets the needs of children identified with mental health challenges.

A licensed mental health professional/consultant will visit your child’s classroom and work with the teacher to help make sure that he/she is learning to: express feelings and emotions, control anger, follow the rules and routine, problem solve, make friends and have a good relationship with their teacher, parents and other important adults. Once the initial screenings take place, the results will be discussed with you. If any concerns are identified, a prevention plan will be developed for the classroom and home. If the prevention plan is not effective, the program staff will ask you for a **separate consent form** for more individualized services.

I give permission for CAHSD Head Start/Early Head Start’s Mental Health Consultant to gather information about *(Child’s Name)* _____ to assist in developing and providing planned activities and supports in the classroom that will foster positive social and emotional development. This may include conducting a general classroom observation, reviewing his/her Head Start file, consulting with Head Start staff, asking Head Start staff to gather information on his/her classroom functioning, and asking parents to share concerns about his/her behavior at home. I understand the Mental Health Consultant will be a licensed mental health professional appointed by the agency.

If the Mental Health Consultant recommends developing an individualized Follow up Intervention plan for him/her in the classroom, I will be invited to participate in its development.

I understand that all information collected will to be kept confidential and can only be released with my written consent.

Please read the statements below regarding mental health consultation services for children with mental health challenges:

_____ I understand that should my child require more intensive services, including the use of an individualized observation, assessment and plan, I will be asked to complete a **separate consent form** and be invited to attend a meeting with the Mental Health Consultant and HS/EHS staff. If the Mental Health Consultant believes my child could benefit from mental health treatment services, the consultant will meet with me to discuss a possible referral for further evaluation by the pediatrician, FDLRS/Early Steps and/or to a mental health provider. A referral by Head Start for mental health treatment and related services can only be made with my written permission.

_____ I understand that I have the right to decline such services and that the program will continue to develop a plan to individualize for services in the classroom should I wish to do so.

By signing below, I acknowledge that the **Parental Consent for Early Childhood Mental Health Consultation Services** form has been reviewed with me and I have been provided with a copy.

 Parent Signature

 Staff Signature

 Date

 Date