



NOCAC- Head Start Program

1933 EAST SECOND STREET
DEFIANCE, OHIO 43512
TELEPHONE (419) 784-2150
www.nocac.org

CONSENT TO TRANSPORT

I, _____ hereby give my consent for my child _____ to be transported by NOCAC Head Start staff for an appointment with _____. The location of the appointment is at: _____. **Your child's appointment is scheduled on: _____ at _____**

We will leave the center at _____ We plan to return to the center at _____

Type of transportation: _____

Child's home address: _____

Phone number where you can be reached during this time: _____

NOCAC Staff members who are scheduled to help transport your child:
_____ and _____

In the event that your child should not be back to the Head Start center in time to go home on his/her normal bus route, he/she will be transported to the address listed above.

I understand that this treatment has been recommended as necessary or advisable for my child by a physician or a dentist, and I understand the nature of the treatment. The purpose of this consent form has been explained to me. This consent is valid for one year after the date signed.

Parent/Guardian Signature: _____ Date: _____

Signature of NOCAC Head Start Staff: _____