



CHILD HEALTH CONSENT

I, _____ give my permission to the Clark
County Health Department to complete the following for _____

(DOB: _____):

1. **NECESSARY EXAMINATIONS:**

- Physical Assessments
- Height
- Weight
- Other Measurements as needed

2. **LAB TESTING:**

- Hemoglobin
- Lead Screening
- Other (ex: Diabetes Screening) _____

3. Contact physician in regards to health records and any abnormal findings at WIC appointments.

4. Developmental Screening

Signature _____

Witnessed by _____

Date _____

This institution is an equal opportunity provider.