I, give Taylor County Public Health consent to provide my child with Child Health Services by a Registered Nurse, Social Worker, or other qualified staff.

Child Health Services may include the following: Initial next to each service:

- [ ] Education/Anticipatory Guidance
- [ ] Assistance Getting a Doctor or Dentist
- [ ] Assistance Getting Insurance
- [ ] Assistance Linking to Community Resources
- [ ] Assistance Getting Transportation
- [ ] Assistance Getting Interpreter Services
- [ ] Referral and other care coordination services
- [ ] Capillary blood draws and lead poisoning prevention education
- [ ] Immunizations
- [ ] Developmental screenings

- A copy of the agencies Notice of Privacy Practices was made available to me on ______________. (insert date)
- I understand that these services are provided through the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand that records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureau of Family Health or Bureau of Oral and Health Delivery Systems), Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.
- Medicaid will be billed for eligible services.
- Fee may be charged for those over 200% of poverty.

This consent for services is valid for one year unless withdrawn in writing by parent, or guardian, or client (if of legal age).

Signature of Parent, Guardian, or Client (if of legal age) _______________________________  Date ___________________________