DOÑA ANA COUNTY HEAD START
Medically Fragile Release

New Mexico State University
Box 30001/ Dept. 3R
Las Cruces, NM 88003-8001
(575) 647-8733

(Must be accompanied by an Authorization to Release)

To: _____
(Health Care Provider)

Re: _____ _____
(Child's Name & Date of Birth) (Parent's Name)

Center: _____ Date:_____

The following conditions require a Primary Care Provider's consent for a child to participate in the normal, daily activities of the Head Start Program:

- ☐ Food Allergies
- ☐ Need for Medication
- ☐ Medical Conditions (heart, blood disorders, seizures, etc.)
- ☐ Asthma
- ☐ Syndromes
- ☐ Disorders
- ☐ Other Please Explain: _____

Please indicate whether the child mentioned above will be able to participate in the Head Start Program.

☐ Child may participate in all activities;

☐ Child may participate in the program, with modifications (please provide any recommendations that would assist our direct service staff in implementing our Head Start preschool activities):

_____
_____

☐ Child will be unable to participate in the program (please explain):

_____
_____

_____ _____
Signature of Health Provider Date

ENTERED INTO CHILDPLUS
BY:_____
DATE:_____