

**Turn-Around Communication/Referral Form  
Between EES and Head Start/Early Head Start**

**05-17**

**EES**

Client Name: \_\_\_\_\_ Person ID#: \_\_\_\_\_

Child Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Telephone Number: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EES Worker: \_\_\_\_\_ Date: \_\_\_\_\_

**Head Start/Early Head Start**

Client Name: \_\_\_\_\_ is participating in Head Start/Early Head Start activities.

Comments/Questions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Head Start/Early Head Start Staff: \_\_\_\_\_ Date: \_\_\_\_\_

Permission to Release Information: My signature on this form authorizes the Kansas Department for Children and Families (DCF) and Head Start/Early Head Start to share information about my situation. This release is valid from the date set out below and shall remain valid until revoked in writing by the undersigned.

\_\_\_\_\_  
Client Signature \_\_\_\_\_ Date \_\_\_\_\_

