PARENT/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

- This consent will remain in effect until your child transfers to another school district, graduates or you indicate in writing that you wish to rescind this consent for school health services.
- When necessary, emergency health services such as first aid, cardiopulmonary resuscitation (CPR) or use of an automated external defibrillator (AED) will be performed until emergency medical services arrive on campus.
- Separate parent/guardian authorizations will be required for the school clinic staff or school staff to administer daily or as-needed prescribed or over-the-counter medications, conduct medical procedures or provide medical treatment.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL CLINIC IF YOU CONSENT AND WISH FOR YOUR CHILD TO RECEIVE ANY OF THE SCHOOL HEALTH SERVICES LISTED BELOW.

Print all information using an ink pen

Student Information

				Male ☐
First Name	Middle Name	Last Name	Student Birth Date	Female ☐

Street Address	Apartment Number	City	State	Zip Code

Parent/Guardian Information

First Name	Middle Name	Last Name	Relationship to Student (parent or guardian)

Street Address	Apartment Number	City	State	Zip Code

Home Phone Number	Work Phone Number	Cell Phone Number		

Indicate which services you give consent and would like your child to receive at school with an "x" in the check boxes.

Care and treatment for illness and injury	☐
Vision screening	☐
Hearing screening	☐
Scoliosis screening	☐
Growth and development screening (body mass index)	☐
Dental screening and dental sealants	☐
COVID-19 testing	☐

Parent/Guardian (PRINT) _____ Parent/Guardian (SIGNATURE) _____ Date _____