

Student Information

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

							∣ iviale ⊔	
First Name Middle Na		me Last Nam		e Student E		Birth Date	Female □	
Street Address		Apartment Number		City		State		Zip Code
Parent/Guardian Info	rmation							
First Name Middle Na		ime	Last Name		Relationship to Student (parent or guardian)			
Street Address		Apartment Number		City	State		Zip Code	
Home Phone Work Pho Number Number		ne	Cell Phone Number					
ndicate which servion	ces you giv	e consent	and would	d like your	child to re	ceive at so	chool with	an "x" in
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								
D		D	2	ONIATURE'		Dete		
Parent/Guardian (PRINT	1)	Parent/0	Guardian (SI	GNATURE)		Date		