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 the 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/Type all Information Requested

Student Information:

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

Street Address	Apartment #	City	State	Zip Code

Parent/Guardian Information:

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

Street Address	Apartment #	City	State	Zip Code

Home Phone Number	Work Phone Number	Cell Phone Number	Notes:

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

	Yes	No
Care and treatment for illness and injury	☐	☐
Vision screening	☐	☐
Hearing screening	☐	☐
Growth and development screening (body mass index)	☐	☐
Mental Health	☐	☐

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