



## 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 <input type="checkbox"/>
First Name	Middle Name	Last Name	Student Birth Date	Female <input type="checkbox"/>
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	<input type="checkbox"/>
Vision screening	<input type="checkbox"/>
Hearing screening	<input type="checkbox"/>
Scoliosis screening	<input type="checkbox"/>
Growth and development screening (body mass index)	<input type="checkbox"/>
Dental screening and dental sealants	<input type="checkbox"/>
COVID-19 testing	<input type="checkbox"/>

\_\_\_\_\_  
Parent/Guardian (PRINT)

\_\_\_\_\_  
Parent/Guardian (SIGNATURE)

\_\_\_\_\_  
Date