Student Name: _____ Student ID Number: _____

PARENT/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

Consent For School Health Services

- This consent will remain in effect for one school year or until 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 nurse 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.

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

YES, I give consent NO, I do not to give consent

	Yes	No
Vision screening	☐	☐
Hearing screening	☐	☐
Scoliosis screening	☐	☐
Growth and development screening (body mass index)	☐	☐
Dental screening and dental sealants	☐	☐

I acknowledge that I have reviewed the District's resources identifying my rights, (Parent's Bill of Rights, F.S. 1014.01). My acknowledgement and my consent are indicated by my signature below.

_____
Parent/Guardian Name (print)

_____ _____
Parent/Guardian (Signature) Date