



782 Wave st
 Sebastian, FL 32958
 (772) 388-8838

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.

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

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

	YES	NO
Care and treatment for illness and/or injury	<input type="checkbox"/>	<input type="checkbox"/>
Vision Screening	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Screening	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis Screening	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development Screening (body mass index)	<input type="checkbox"/>	<input type="checkbox"/>

My acknowledgement and my consent are indicated by my signature below.

Student Name: (print): _____

Grade: _____

Parent Name (print): _____ Parent Signature: _____ Date: _____