THE SCHOOL DISTRICT OF PALM BEACH COUNTY
STUDENT HEALTH AND WELLNESS

Student Health Information and Parent/Guardian Consent for School Health Services

This is to be completed by the parent/guardian and returned to the school to provide student health information and consent for the student identified below to receive any of the school health services listed below. All items must be completed.

Student #	Student First Name	M.I.	Last Name	Gender	Birth Date

Parent/Guardian First Name	Last Name	Phone Number	Relationship to Student

As required by F.S. 1014.06(1), parent or legal guardian must authorize healthcare services to be provided for their student by a healthcare practitioner or their delegate, as defined in F.S. 456.001 and 1006.062, should the need arise for such treatment, while their student is under the supervision of the school.

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.

For each service choose Yes or No:

Health care services including care and treatment for illness and injury: ☐ Yes ☐ No

Yes - response will authorize such treatments including, but not limited to, major or minor injury or illness reported or observed while the student is at school. Failure to respond will result in an indication of "no" for healthcare treatment.

No - response will result in calls to the parent or guardian for the student to be picked up for all medical concerns. This will be for all instances where students are feeling ill, have a headache or injuries such as cuts, scrapes, bumps, or bruises. EMS will be called for any situation deemed serious.

Students will receive non-invasive health screenings for hearing, scoliosis, growth and development (BMI), vision and dental pursuant to F.S. 381.0056(6)(e), unless the parent or guardian opts out by checking "no" in the box below. *(Permission is valid until revoked by parent. See District Student and Family Handbook for more information.)*

Hearing screening: ☐ Yes ☐ No

Scoliosis screening: ☐ Yes ☐ No

Growth and development screening (body mass index): ☐ Yes ☐ No

Vision screening: ☐ Yes ☐ No

Dental screening: ☐ Yes ☐ No

The sodium fluoride program is offered at schools without fluoride in the local water supply. I give permission for my student to participate in the sodium fluoride program to prevent tooth decay. ☐ Yes *(permission is valid through grade 5)* ☐ No

Allergies, Medications, Medical Concerns and Physician Information

Does the student have life threatening allergies? ☐ Yes *(if yes, provide a list to the nurse)* ☐ No

Does the student take medication? ☐ Yes *(if yes, provide a list to the nurse)* ☐ No

Does the student have medical concerns? ☐ Yes *(if yes, provide a list to the nurse)* ☐ No

Does the student have a referral for mental health services associated with a school expulsion, arrest resulting in a charge, or juvenile justice action? ☐ Yes ☐ No

Student health insurance *(check all that apply)* ☐ Medicaid ☐ Healthy Kids/Kid Care ☐ Private ☐ No Insurance

Physician Name _____ Physician Phone Number _____

Note: This form, in addition to a physician's authorization, 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.

I understand that this consent will remain in effect until the above named student transfers to another school district, graduates or I indicate in writing that I wish to rescind this consent for school health services.

_____ _____ _____

Parent/Guardian Printed Name *Parent/Guardian Signature* *Date*