HEALTH CONSENT FORM 2015-2016

STUDENT LAST NAME

STUDENT FIRST NAME

GRADE_____

I hereby consent and authorize this facility, its staff, nurse and/or cooperating physicians to provide health related services to my child _____.

These services may include physical examinations, immunizations, treatment of acute common illnesses, health screenings, health education and counseling, dental screenings and education.

I understand that these records and the data they contain will not be released to any person or agency without my express written consent.

I understand that I am responsible for health care if any follow-up is recommended.

If you do not wish your child to receive certain services mentioned above, please specify below:

_____

_____

Parent's/Guardian's initials for **opting out** of specific services _____

In order to provide improved services for your child, please indicate if your child has any of the following illnesses:

___ Allergies (please specify)

___ Arthritis

___ Asthma

___ Diabetes

___ Other (please specify) _____

___ Hemophilia

___ Seizures

___ Sickle Cell

___ Heart Problems

Child's Healthcare: _____ Doctor/Clinic _____ Emergency Room _____None

Doctor/Clinic Name _____

Doctor/Clinic Phone Number _____

I certify that I understand the contents of this form, which I have read or have had translated to me.

Parent/Legal Guardian's Signature_____ Date _____