



THE SCHOOL DISTRICT OF PALM BEACH COUNTY
EQUITY AND WELLNESS

Parent/Guardian Consent for School Health Services

This is to be completed by the parent/guardian and returned to the school to 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.

Hearing screening: Yes No

Scoliosis screening: Yes No

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

Vision screening: Yes No

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 Signature

Parent/Guardian Printed Name

Date