*One form for each child*

**2023-2024 School Health Consent Form**

Student's Last Name: _____ Student's First Name: _____

Date of Birth: _____ Grade: _____ Male _____ Female _____

Doctor Namer: _____ Clinic: _____ Phone: _____

Dentist Name: _____ Clinic: _____ Phone: _____

Does the student have any **ALLERGIES** (food, medication, environmental, or other)? Yes _____ No _____

If yes, please explain _____

Does the student have an **EPI PEN**? _____ Yes _____ No

Does the student have any **MEDICAL CONDITIONS**? ____ Yes _____ No

**ASTHMA**: _____ Yes _____ No If yes, does the student have an inhaler? _____ Yes _____ No

**DIABETES**: _____ Yes _____ No **SEIZURES**: _____ Yes _____ No **WEARS GLASSES**: _____ Yes _____ No

**HEARING DEVICE**: _____ Yes _____ No **OTHER**: _____

Does the student take any **MEDICATION(S)**? Yes _____ No_____

If yes, please explain _____

**iF YOUR CHILD NEEDS A PRESCRIPTION MEDICATION WHILE AT SCHOOL (INHALER, EPIPEN, ETC), WE MUST HAVE A MEDICATION AUTHORIZATION FORM SIGNED BY YOUR CHILD'S DOCTOR AND A PARENT/GUARDIAN. YOU CAN REQUEST THIS FORM FROM THE SCHOOL OFFICE OR SCHOOL NURSE. *AN UPDATED FORM IS REQUIRED EVERY SCHOOL YEAR.**

I give permission for my child listed above to receive health services from the St. Joseph Academy School Nurse. I understand these services could include physical examination, health screening, and treatment for illness or injury. If needed, I will allow the school nurse to administer:

_____ ACETAMINOPHEN (Tylenol) _____ IBUPROFEN (Advil) _____ COUGH DROPS

**ALLERGY INFORMATION MUST BE COMPLETED BEFORE ANY MEDICATION WILL BE GIVEN**

A record will be kept of all treatment given to my child. If my child would need emergency treatment, I give permission for him/her to be transported to an emergency medical facility. I consent to the exchange of relevant health information (including information about physical exams, health histories, and other information between the school nurse and school personnel in order to meet the health needs of my child. I agree to allow information to be released to our family physician or any medical referral source and I authorize our family physician to share relevant medical information with the school nurse. **Your child cannot be seen for non-emergency care without this signed consent form.** This consent expires September 15, 2024.

Signature: _____ Print Name: _____ Date:_____ /_____ /_____

Relationship to child: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

**If my child becomes ill and I cannot be reached, please contact the following person:**

Name: _____ Relationship to child: _____ Phone:_____