

# Consent for School Clinic Health Services

Please complete this form to authorize the school clinic to provide basic medical services, first aid, and emergency care to your child. Once completed, this form can be printed for school records.

## Student Information

Student Full Name:

Date of Birth (MM/DD/YYYY):

Grade Level:

Homeroom Teacher:

## Parent/Guardian Information

Parent/Guardian Full Name:

Relationship to Student:

Primary Phone Number:

Email Address:

## Medical Information & Allergies

Known Medical Conditions (if any):

Known Allergies (Food, Medication, Environmental):

Current Medications:

## Consent Terms

By signing below, I hereby give consent for the school nurse or designated school clinic personnel to administer first aid, emergency care, and approved over-the-counter medications to my child as deemed necessary. In the event of a serious medical emergency, I understand that emergency medical services (911) will be contacted and my child may be transported to the nearest hospital.

## Authorization & Signature

Parent/Guardian Signature (Type Name):

Date (MM/DD/YYYY):