Ware County School Health Services
Parental/Guardian Consent for School Health Services for School Year 2023 - 2024

Student Information

Student Name: _____ DOB: ___/___/___ Sex: _____ Race: _____
School: _____ Homeroom Teacher: _____ Grade: _____
Parents/Guardians Name(s) _____
Phone # _____ Phone # _____Phone #_____
Parent/Guardian #1 Place of Employment _____ Work Phone _____
E-mail Address_____
If parent cannot be reached contact _____ Phone_____
If parent cannot be reached contact _____ Phone_____

Student Health Status

Local Doctor: _____ Specialist Doctor: _____ Dentist: _____
List **all medications** taken at home: _____

Does your child have any of the following health conditions?

Condition	Yes	No	Treatments	Yes	No
Asthma			Does your child have an inhaler or nebulizer?		
Diabetes			Does your child take Insulin?		
Seizures/Epilepsy			Does your child take medication for seizures?		
Severe Allergies to Meds/Foods/Etc.			Does your child have an EpiPen?		
Hearing Problems			Does your child wear hearing aids?		
Vision Problems			Does your child wear glasses/contacts?		
Cerebral Palsy					
Heart Problems/Defect					
Cystic Fibrosis					
Sickle Cell Disease					

If you checked YES to any chronic conditions or severe allergies listed or if there is another health condition, it is YOUR responsibility to contact the school nurse about having a care plan on file. Please provide details to any YES conditions on the back of this form. Also, list any additional health conditions with details of the condition on the back of this form.

Parental/Guardian Consent for School Health Services

I give my consent for the above-named child to participate in the School Health Services Program, which may include vision, hearing, height, weight, body mass index, nutrition, dental, scoliosis screenings, health appraisals, & nursing assessment.

I give my consent for my child to receive routine first aid administered by the school nurse or principal designee in the case of minor accidents or injury.

I give permission for the school nurse or principal designee to provide emergency care and to seek emergency medical services for my child if necessary.

I give consent for the nurse or principal designee to administer over the counter medications for minor discomforts and/or fever when needed. **Over the counter medications will be given according to the manufacturer's recommendations for the listed purpose with dosing based on the age and/or weight of the student.** Any dose that exceeds the manufacturer's recommendations will require a physician's order. **Over the counter medications available in the clinics are**: *Allergy Medication, Antacid, Antibiotic Ointment, Antidiarrhea Medication, Antifungal Cream, Anti-Itch Cream, Benadryl, Burn Spray/Gel, Carmex, Chloraseptic Spray, Non-Drowsy Cold/Sinus Medication, Cough Drops, Cough Syrup, Earache Drops, Eye Drops (Allergy Eye Drops, Visine, Contact Solution, Stye Eye Relief), Gas Relief Meds, Ibuprofen, Insect Bite Spray, Midol, Muscle Rub, Nausea Medication, Oragel, Pepto Kids, Tylenol (Acetaminophen), and Vicks Vapor Rub.* **If you prefer that your child DOES NOT receive ANY over the counter medications, please indicate this in writing on the back of this form. If you prefer that your child DOES NOT receive a specific medication listed, please indicate which medication is NOT to be given to your child on the back of this form.**

Parent/Guardian Signature X_____ Date: _____

Please List Severe Allergies to Medications/Foods/Insect/Etc. and describe the allergic reaction (hives, etc.)

Please provide further information on health conditions marked or provide information for any other conditions your child may have that are not listed on this form.

If you prefer that your child DOES NOT receive a SPECIFIC over the counter medication listed on the previous page, please indicate which medication is NOT to be given to your child here.
Do NOT give my child this/these over the counter medications:

If you have any additional specific requests regarding medication administration or care, please comment below: