Community Health Network

Permission for School Nurse Services

The School Nurse program is staffed by nurses from Community Health Network and can provide limited services to any child who feels ill during the day. This is a School clinic, and not part of Community Health Network, and all records are maintained by the School. There is no charge to you for the services. If you DO NOT want your child to have access to the clinic, notify the School clinic in writing, in advance. In an emergency situation to prevent death or serious injury, the School Nurse and School staff will act to prevent such injury or death and stabilize the situation.

School: _____ Grade _____ Effective July 1, 2020 – June 30, 2021

I give permission for _____
Please print student's: Last Name, First Name Middle Initial Date of Birth

to receive health services from the school nurse health clinic (Clinic) at my child's school. I understand that Clinic personnel cannot take care of all the health needs my child may have, but will work with outside physicians and providers who are providing ongoing care, as needed. Please provide a copy of any Plan of Care developed for the child named above, and specific information about any treatment or medication that needs to be administered during the school day.

I. <u>I give consent for my child to receive Clinic services</u>: I have read the information about the Clinic and understand what services the Clinic may provide, which include, but are not limited to: (a) Care prescribed by a physician or other qualified practitioner and established, through discussions with me, as a "Plan of Care" for my child, plus (b) first aid/emergency care, referrals to health providers in the community, health education, health screenings and immunization information. It will be my responsibility to notify the Clinic staff about changes in any Plan of Care, as well as changes in guardianship, the child's living or custody arrangements, and contact numbers.

If my child needs over the counter or prescription medications during the school day, I will complete and attach a "Request to Administer Medication" form for each medicine.

Signature of Parent or Guardian (if student under age 18): _____ Date: _____

Signature of Student (if 18 or older or emancipated): _____ Date: _____

II. <u>Release of Information</u>: In addition to using health information about the student named above to treat the student's injuries and illnesses and for clinic administration, I hereby authorize the use and disclosure of the health information as needed to the applicable school administration or staff to evaluate the student's eligibility to participate in school activities, or to resolve grievances. In addition, I give my consent to the school-based health clinic staff to look at my child's full school record, including attendance, in order to provide information that may assist the clinic staff in helping my child. I understand that the Clinic will not restrict services to the student based on my decision not to sign below for this Authorization, but that the student's participation in certain school sponsored activities may be conditioned on the signing of this Authorization.

Expiration of Authorization: This Authorization expires as of the date in the upper right corner, and may be revoked in writing at any time prior to its expiration date, except to the extent that action has already been taken in reliance on this Authorization. Send or hand deliver a written revocation to a member of the Clinic staff.

Signature of Parent or Guardian (Student under 18): _____ **Date:** _____
Printed: _____

Signature of Student (18 or older or legally emancipated):_____**Date:**_____