Community Health Network

Permission for School Nurse Services FTCSC

The School Nurse program is staffed by nurses from Community Health Network. This is a School clinic, and not part of Community Health Network. All records are maintained by the School. There is no charge to you for the services. School nurses may provide non-emergency first aid treatment, emergency care, and conduct health screenings to students, without the return of this permission form. To approve use of clinic records to determine eligibility for the student to participate in school activities, and for additional healthcare services described in Section I, please return this form, as well as a Request to Administer Medication form for any medication to be administered to the student. If your child has or needs a Plan of Care for recurring treatment, please also submit that information with this form.

School Year Beginning: 2023 - This consent is effective July 1, 2023 through July 1, 2024

School District: _____

Student Name: _____

Student Date of Birth _____

I. Consent to Treat: I give permission for my student to receive additional healthcare services from the school nurse clinic at his/her school. I understand that nursing personnel cannot take care of all the health needs a student may have. The school nurse is available to assist you in locating health resources that may benefit your student.

I have read this information and understand what additional healthcare services the clinic may provide, which include, but are not limited to: (a) specialized treatment not considered an emergency, (b) Care prescribed by a physician or other qualified practitioner and established, through discussions with me, as a "Plan of Care" for my child, and (c) Referrals to health providers in the community. It is 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. Release of Information: 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.

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

Printed: _____

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

OR:

Form read to/verified with parent/guardian listed above, and verbal consent witnessed by school personnel _____
[Printed Name of Witness]

on _____ (Date consent obtained).

Termination of Permission: This Permission 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.