Clayton County Public Schools
School Health Program

Clayton County Public Schools has established a School Health Program that provides a healthcare technician at your child's school during the school year. If you <u>**choose**</u> for your child to participate in the School Health Program, the healthcare technician/designee must have your permission and some important health information about your child. **<u>Please complete this form and return to the healthcare technician at your child's school.</u>**

Student's Name ______________________ ________ Date of Birth ______________________
School ______________________________________ Teacher ______________ Grade__________
Street Address ____
Parent/Guardian ______________________________ Home Phone ____________________
Mother's Work Phone ________________________ Father's Work Phone ________________
Mother's Cell Phone _________________________ Father's Cell Phone _________________
Emergency contact #1 ____________________________ Relationship __________________
Home Phone ______________________ Cell phone _________________________
Emergency contact #2 ____________________________ Relationship __________________
Home Phone ______________________ Cell phone _________________________
Student's Primary Physician ______________________________ Phone _______________
Does your child have any specific health need or chronic health condition? NO _____ Yes (explain) __________
____
Does your child have an allergy (food, medication, other)? NO _____Yes (please explain) ______________
____
Does your child take medication daily? NO ______ Yes (please explain) ____________________
Side effects from medication: ____

The School Health Program provides the services listed below:

- Assessment and evaluation of sudden illness while in school
- Basic First Aid
- Medication Administration (Medication Authorization required)
- Vision, Hearing and Scoliosis Screening
- Health and Nutrition Education
- Referral for illness/injury not suitable for treatment in the school
- Asthma management (Asthma Health Plan and Medication Authorization required)
- Diabetic management/Glucose monitoring (Diabetic Health Plan and Medication Authorization required)
- Seizure management (Seizure Health Plan and Medication Authorization required)
- Allergic Reaction management (Allergic Reaction Health Plan and Medication Authorization required)

If an emergency arises requiring treatment for your child, every effort will be made to contact you immediately. **<u>In the event of the life threatening situation, 911 will be called.</u>** Doctors and hospitals are very conscious of liability suits and will not treat a child without parental consent. Your signature gives us authority to seek emergency medical treatment. **The Clayton County Public School System assumes no financial responsibility for actions taken to preserve the health and well being of the said student.**

I, UNDERSIGNED, HEREBY GIVE THE PERMISSION TO CLAYTON COUNTY PUBLIC SCHOOLS FOR MY CHILD TO PARTICIPATE IN THE ABOVE SERVICES OF THE SCHOOL HEALTH PROGRAM. THE HEALTHCARE TECHNICIAN/DESIGNEE HAS MY PERMISSION TO CONTACT MY CHILD'S PHYSICIAN FOR FURTHER MEDICAL INFORMATION AS NECESSARY. I UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANY TIME BY WRITTEN NOTIFICATION TO THE SCHOOL.

Parent/Guardian Signature ______________________________________ Date ____________