Glascock County Youth Health Services
Consent Form (Pre-K)

Student Name_____ Grade_____ Teacher_____

DOB_____Doctor_____Phone_____

Health History – Does your child now have or has he/she ever had:

Asthma	YES/NO	Learning Disability	YES/NO	Physical Education Limitations	YES/NO
Diabetes	YES/NO	Hearing Problems	YES/NO	Food Allergies	YES/NO
Seizure Disorder	YES/NO	Vision Problems	YES/NO	Other illness (list)	
Limitations (list)	YES/NO	Wears glasses/contacts	YES/NO	List Allergies (food, environmental, medications)	

Please explain any **YES** answers. Give as much information that will help your school nurse understand and assist with your child's needs: _____

_____

Medications taken at home (list) _____

IF YOUR CHILD HAS ASTHMA
Will he/she need to carry his/her inhaler at school? **Yes / No.** If yes, an Asthma Action/Safety Plan will be required (available in the clinic).

IF YOUR CHILD HAS A SEVERE ALLERGY
Will he/she need to carry his/her EpiPen at school? **Yes /No.** If yes, an Emergency Action/Safety Plan will be required (available in the clinic).

Tylenol is the only medication offered for Pre-K. Please indicate if your child is allowed to have Tylenol.
Yes_____ No_____

Parent/Guardian_____Address:_____

Home#_____ Cell#_____Email_____

Medicaid/Peachcare No._____Other insurance name and no._____

In case of emergency, if unable to reach parent/guardian, contact:

Name/Relationship/phone:_____

Please sign ONLY ONE of the following lines:

YES, I give permission for my child to receive free services from the school clinic. I understand that all services are confidential. I have given accurate and complete information to the best of my knowledge. I realize this permission is in effect until notified in writing otherwise. In the event of a major accident or serious illness, school clinic personnel have my permission to transport my child to the nearest healthcare facility via emergency medical services if I am unavailable to be reached in the event of an emergency. Fees for transport and medical services will be the responsibility of the Parent/Guardian signed below. This permission remains in effect from the date of this document through 12th grade unless revoked in writing. I agree to update this document if healthcare and contact information changes.

Parent/Guardian_____Date_____

NO, I do not want my child to receive non emergency health services. I agree to be immediately available to provide care for my child at school at ALL times.

Parent/Guardian_____Date_____