

Dawson County Youth Health Services Pre-K Consent Form

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)	
Physical 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# _____ Work# _____ Email _____
 Medicaid/Peachcare No. _____ Other insurance name and no. _____

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

Name/Relationship/phone: _____
 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-emergent health services, and I agree to be immediately available to provide care for my child at school at ALL times.

Parent/Guardian _____ Date _____