Dawson County Youth Health Services
Consent Form

Student Name_____ Grade_____ Teacher_____
DOB_____Doctor_____Phone_____

Health History – Does you 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** Where is the inhaler located? **Clinic or on Students**? If yes, an **Asthma Action/Safety Plan** will be required (available in clinic or on website).
IF YOUR CHILD HAS A SEVERE ALLERGY
Will he/she need to carry his/her EpiPen at school? **Yes / No** Where is the EpiPen Located? **Clinic or on Student?** If yes, an **Emergency Action/Safety Plan** will be required (available in clinic or website).

Pre-K students will only be administered Tylenol with parent permission: YES or NO

K-12 Only*, STRIKE THROUGH ANY OF THE FOLLOWING MEDICATIONS THAT YOU DO NOT WANT TO BE USED FOR YOUR CHILD** ***Generic Preparations** may be substituted for these listed over the counter products. The Dawson County Schools will not be required to furnish medications but will have these on hand as funds are available

TYLENOL		**COUGH DROPS**		**SALINE EYE SOLUTION**		**SUDAFED PE**	
Ibuprofen		**CALAMINE LOTION**		**ORAJEL**			
MYLANTA/TUMS		**HYDROCORTISONE CREAM**		**VASELINE/VICK'S VAPOR RUB**			
BENADRYL liquid/ointment/ spray		**ANTIBIOTIC OINTMENT**		***CHILDREN'S COUGH SUPPRESSANT AND/OR EXPECTORANT (guaifenesin and/or Dextromethorphan)**			

Parent/Guardian_____ Address:_____
Home#_____ Cell#_____ Work#_____ Email_____
In case of emergency, if unable to reach parent/guardian, contact: (listed person will be allowed to pick up my child from school)
Name/Relationship/phone:_____
Name/Relationship/phone:_____

Does your child have insurance? Yes or NO

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, I understand that the school will make every effort to contact me. 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.***

Date_____ Parent/Guardian signature_____

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_____
REV. 8/17