PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES 2020-2021

School:_____ **Teacher:**_____ **Grade:**_____

WHAT IS THE SCHOOL HEALTH SERVICES PLAN?

This School Health Services Program is designed to appraise, protect and promote the health of our students as well as provide preventive and emergency school-based health services in accordance with the Whole School, Whole Community, Whole Child (WSCC) model and the School Health Services Plan for Bay County.

BDS SCHOOL HEALTH SERVICES PROGRAM INCLUDES:

The following health care services are provided by the district's health care partner, PanCare of Florida, Inc. I give consent to the following services (***parents initial items to which you consent***):

Initials:_____**School Health Room Services**

- Basic First Aid Services
- Assist student with physician ordered medication administration (BDS permission form required)

Initials:_____**School and Sports Physicals**

- Physicals provided by a Florida Licensed Medical Provider

Initials:_____**Preventative Dental Services**

- Dental exams provided by a Florida Licensed Dentist
- Dental cleanings provided by a Florida Licensed Dental Hygienist
- Dental sealants applied to molars as needed by a Florida Licensed Dental Hygienist

Initials:_____**TeleHealth/Telemedicine Services**

- School health nurse connects student with PanCare (Florida Licensed) Medical Providers during a TeleHealth encounter
- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, influenza, etc.
- If needed, the health care provider can write a prescription and send it electronically to the family's pharmacy

Initials:_____**Mental and Behavioral Health/Wellness Services**

- Counseling, psychiatry, medication management, and therapy

School Health Screenings

Florida Statue 381.0056(7)(d), mandates regular health screenings to public school students. The screenings include vision, hearing, height and weight, Body Mass Index (BMI) and scoliosis (6th grade only). As well as a behavioral health well-being questionnaire for students 12 years & older. **Any parent choosing to decline this required school health screening must provide a written communication to the school administrator.**

PRINT STUDENT'S FIRST AND LAST NAME:_____ **Date of Birth:**_____

PRINT PARENT'S FIRST AND LAST NAME:_____

PARENT/LEGAL GUARDIAN SIGNATURE:_____ **Date:**_____

The above consent statements will remain in effect until the parent/legal guardian submits a new School Health Services Consent form.

BDS Student Emergency Information Card

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis. **This form is required for access to all health services, as well as field trips and extra-curricular activities.** It is the parent's responsibility to provide the school with any changes or updates to your child's information.

Student Information		
Last	First	Middle
Address		
School	Grade Level/Homeroom Teacher	

Parent Information		
Last	First	
Cell Phone	Work Phone	Home Phone
Emergency Contact		
Last	First	Relationship to Student
Cell Phone	Work Phone	Home Phone

Is the student a child of an active duty military family? ☐YES ☐ NO If yes, which branch? _____

Is the student a child of a Department of Defense Employee? ☐YES ☐NO

Medical Information

Health Insurance YES/NO Insurance Company: _____ Policy # _____

Medicaid # _____ Tricare Sponsor ID # _____ Florida Kid Care: YES/NO

Does your child take medication? ☐ YES ☐ NO

If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. Before medication can be dispensed, a **"Permission to Administer Medication"** form must be completed and signed by the physician and the parent and must be on file at the school.

Medication	Dosage	Hour(s) Given

Does your child wear contacts/glasses? ☐YES ☐NO

Does your child wear hearing aid(s)? ☐YES ☐NO

Check all that applies to your child:

- ☐ Asthma If checked, uses inhaler/medication? ☐ Yes ☐ No
- ☐ Seizures If checked, on medication? ☐ Yes ☐ No
- ☐ Diabetes If checked, insulin dependent? ☐ Yes ☐ No
- ☐ Cystic Fibrosis If checked, on medication? ☐ Yes ☐ No
- ☐ Movement Limitations _____
- ☐ Recent illness/hospitalization/surgery (describe) _____
- ☐ Severe allergies? If checked, please specify: _____
- ☐ Food/environmental ☐ Insect stings/bees ☐ Medicines/Drugs Other: _____ Allergies Require: ☐ EpiPen ☐ Benadryl
- ☐ Other Medical Needs:

Release of Medical Information & Emergency Treatment

I understand and agree that certain educational health related records of my child will be shared with the district's health care partners (which include PanCare of Florida, Inc., & the Department of Health, Bay County) as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by the health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I further authorize the district's health care partners to contact my child's pediatrician(s) or physician(s) to obtain personal medical information as it pertains to student health services.

I hereby consent to my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) being shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions.

The school has my permission to seek emergency medical treatment in case of a serious accident or illness. In case of an accident or illness where immediate treatment of my child is not indicated but where he/she is unable to remain in school, I request that the person(s) listed on FOCUS Parent Portal be contacted and requested to care for my child in the event I cannot be reached. I also authorize the exchange of medical information as necessary to support the continuity of care for my child. In the event of an emergency while on a school sponsored field-trip or event, I give consent to any and all medical treatments and surgical procedures which may be deemed advisable by a qualified physician.

Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by FERPA. The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

☐ **I DO** ☐ **DO NOT** give consent for Bay District Schools & its contracted partners to bill my insurance/Medicaid for services provided.

☐ **I DO** ☐ **DO NOT** give consent for the Life Management Center Mobile Response Team (MRT) to conduct a screening if my child is in crisis.

Parent Signature: _____ **Date:** _____