PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES
2022-2023

PANCARE OF FLORIDA, INC.

Student Name _____ 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) mode and the School Health Services Plan for Bay County.

ESSENTIAL School Health Services & Screenings

Florida Statue 381.0056 mandates regular health screening to public school students. The screenings include **vision, hearing, height and weight, Body Mass Index (BMI) and scoliosis (6th grade only).** Vision exams provided by a Florida Board Certified Doctor of Optometry for all vision screening failures.

_____ **Yes, I agree to all essential screenings**

_____ **No, I decline all essential screenings**

_____ **Yes, to all except:** _____

Yes _____ No _____ School Health Room Services

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

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

ADDITIONAL BDS School Health Services

The following health care services are also available through the District's health care partner, PanCare of Florida, Inc. Please indicate your choice for each ***optional*** service.

Yes _____ No _____ School Physicals

- Physicals provided by a Florida Licensed Medical Provider

Yes _____ No _____ 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

Yes _____ No _____ Vision Care Program

- Eye exams provided by a Florida Board Certified Doctor of Optometry
- If prescribed, opportunity to order eyeglasses at a discount
- Eyeglass fitting and care instruction provided by a Florida Optician
- Annual eye exams provided, as needed

Yes _____ No _____ Telehealth/Telemedicine Services

- School health nurse connects student with PanCare (Florida Licensed) Medical Providers during a Tele Health encounter
- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, influenza, COVID 19, etc.
- If needed, the health care provider can write a prescription and send it electronically to the family's pharmacy

PRINT STUDENT'S FIRST & LAST NAME _____ Date of Birth _____

PRINT PARENT'S FIRST & LAST NAME _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ Date _____

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

Physician Name _____ Physician Phone # _____

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

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

☐ **I DO** ☐ **I 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:** _____