

Franklin County School Health Services

STUDENT PERMISSION FORM

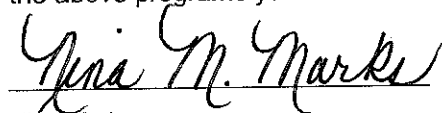
Dear Parent,

The Franklin County School Board and the Franklin County Health Department have continued to receive funding for comprehensive school health staff in our school. The Full Service, Basic and Supplemental School Health Grants allow for the hiring of a Registered Nurse and Licensed Practical Nurses to serve our school.

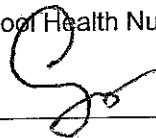
The School Health Staff will be furnishing the following free services:

- | | |
|---|---|
| 1. Vision Screening | K, 1, 3, 6, and as needed (First time entry into Florida schools) |
| 2. Hearing Screening | K, 1, 6, and as needed (First time entry into Florida schools) |
| 3. Scoliosis Screening | 6 & as needed |
| 4. Height & Weight (BMI) | 1, 3, and 6 as needed |
| 5. First Aid | Pre-K-12 |
| 6. Immunization Surveillance | Pre-K-12 |
| 7. Nutritional Assessment and Counseling | Pre-K-12 |
| 8. Age-appropriate Health Education Classes | Pre-K -12 |
| 9. Tobacco Prevention | Pre-K-12 |
| 10. Blood Pressure Measurement | Pre-K-12 as needed |
| 11. Dental Screening | Pre-K-12 as needed |
| 12. Medication supervision | Pre-K-12 as needed |
| 13. Communicable disease | Pre-K-12 |
| 14. Individual student education | Pre-K-12 |
| 15. Screening/education plan | Pre-K-12 |

Participation is voluntary and entirely without cost to your child. We encourage your child to participate in these valuable school preventive health programs. If you *do not* want your child to participate in any of the above programs you will need to notify the School Health Nurse in writing.



Nina Marks
Superintendent of Schools



Eugene Charbonneau, D.O.
FCHD Medical Director

I UNDERSTAND THAT CERTAIN EDUCATIONAL RECORDS OF MY CHILD WILL BE SHARED WITH THE DISTRICT'S HEALTH CARE PARTNERS AS NEEDED TO PROVIDE AND EVALUATE HEALTH SERVICES TO STUDENTS. I ALSO UNDERSTAND AND AGREE THAT MY CHILD'S MEDICAL TREATMENT RECORDS CREATED BY HEALTH CARE PERSONNEL AT SCHOOL MAY BE SHARED WITH SCHOOL OFFICIALS WHO HAVE A LEGITIMATE EDUCATIONAL PURPOSE FOR ACCESSING SUCH TREATMENT RECORDS. PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE REVIEWED THE ITEMS ON THIS FORM. THE STUDENT WILL NEED TO RETURN THIS FORM TO THEIR SCHOOL HEALTH NURSE.

Parent signature and daytime phone number

Student name and grade

Date: _____

Grade: _____ Teacher _____ Date _____

Child's Name: _____ Date of Birth: _____
Last First Nickname

Address: _____ Home Phone: _____

Names of Parents/Guardians with whom student resides (LEGAL CUSTODY)

Name	Relationship	Work Phone	Cell Phone/Pager	Daytime Phone
------	--------------	------------	------------------	---------------

Name	Relationship	Work Phone	Cell Phone/Pager	Daytime Phone
------	--------------	------------	------------------	---------------

Emergency Contact: These persons will assume temporary care of your child in the event you cannot be reached:

Name	Relationship	Work Phone	Cell Phone/Pager	Daytime Phone
------	--------------	------------	------------------	---------------

Name	Relationship	Work Phone	Cell Phone/Pager	Daytime Phone
------	--------------	------------	------------------	---------------

Health Problems _____

Allergies: _____

Medications routinely taken (Indicate name, dosage & schedule): _____

Physician _____ Phone: _____

Type Insurance: School _____ Medicaid _____ KidCare _____ Personal _____ None _____