Aberdeen School District Health Care Services Consent Form
PLEASE RETURN TO SCHOOL

In accordance with Policy 639 – Parental Rights in Education, it is the policy of the Aberdeen School District to obtain parent/guardian consent on *an annual basis* for the provision of health care services to students under the age of 18, except where consent cannot be timely obtained in emergency situations. Health care service means a service for the diagnosis, screening, examination, prevention, treatment, cure, care, or relief of any physical or mental health condition, illness, injury, defect, or disease. In the school setting, health care services may include counseling; treatment of minor injuries or illnesses; first aid; vision, hearing, dental, or scoliosis screenings; immunizations; or crisis intervention. School health care services do not include any of the following: providing or performing an abortion; counseling in favor of abortion; referrals for abortion; or dispensing emergency contraception.

Parents/guardians of students with chronic health conditions, food or other allergies, seizure disorders or epilepsy, asthma, diabetes, or G-tube which may require treatment or monitoring during the school day should contact the school nurse/administrator for development of a health care and/or medication administration plan.

CONFIDENTIALITY AND STUDENT HEALTH RECORDS

All records containing student health information are the property of the district and protected under the Family Educational Rights and Privacy Act (FERPA). No other agency will have access to these records without your written consent. We protect the privacy of your child's health information by:

- Limiting how we use and disclose health information.
- Providing physical safeguards (secure offices and storage facilities, electronic protections, and procedures).
- Training employees about privacy policies and procedures

Student Name:	**Grade**:	**DOB**:
School:	**Gender**: □ Male □ Female	
Parent/Guardian #1 Name:		**Phone (Daytime)**:
Parent/Guardian #1 Email:		**Phone (Cell)**:
Parent/Guardian #2 Name:		**Phone (Daytime)**:
Parent/Guardian #2 Email:		**Phone (Cell)**:
Emergency Contact (other than Parent/Guardian):		
Emergency Contact Phone (Daytime):		**Phone (Cell)**:

Has your child ever attended a District school? □ Yes □ No
If yes, what school(s) did your child attend in the past?_____

My child has the following life-threatening condition(s) that may need emergency treatment or medication (EpiPen, glucagon, emergency seizure medications, asthma inhaler, etc.) at school (check all that apply:

□ Diabetes □ Asthma □ Seizures □ Food allergies □ Other allergies or conditions: _____

For all food or other allergies, please specify the allergy and typical reaction: _____

Child's Other Medical History: Please specify important medical information staff for which staff should be aware (e.g. heart condition, cancer/blood disorders, behavior/emotional, G-tube, etc.): _____

Medications taken every day: _____
Over-the-Counter Medications Authorized: □ No □ Yes Circle all that are authorized: Acetaminophen (Tylenol), Ibuprofen (Motrin), Tums, Cough Drops/Throat Lozenges, Benadryl (only for allergic reactions), Hydrocortisone Cream 1%, Burn Cream, Topical Mouth/Tooth Pain Relievers (Orajel/Anbesol), Antibiotic Ointment (Neosporin/Bacitracin, etc.), Eye Wash/Irrigating Solution, Other: _

Child's Healthcare Provider: _____ Phone: _____
Child's Dentist: _____ Phone: _____

PLEASE READ CAREFULLY

I consent to care for my child that may include screenings, exams, assessments, treatment, first aid, over-the-counter medications as listed on the Consent for Treatment Form, counseling, and any other health services given to my child by licensed and/or unlicensed trained staff, or licensed volunteers/contractors of the [name] School District. I understand that no guarantees are being made as to the effect of any exam or treatment on my/my child. ____(Initial Here)

I authorize the Aberdeen School District to receive and release medical/dental/immunization/vision information about my child to their healthcare provider, immunization registry, or dental or vision provider as needed or requested. _____(Initial Here)

I understand and acknowledge that this consent is valid until revoked by me in writing. _____(Initial Here)

Signature: _____ Date: _____
Print Name: _____