HERNANDO
SCHOOL DISTRICT

PARENT/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

- **Per State Statute 1014.04 and HB 1557,** parental consent is required for the healthcare services listed below. If you agree to allow your student to receive all or any of these services below if/when they are needed, please check the appropriate boxes in each section. Please complete one form for each student and return to your child's homeroom/1st period teacher.
- **Emergency services will be provided to all students according to the standards found in the Florida Emergency Guidelines for Schools https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/reports-information.html**
- This consent will remain in effect for one school year or you may indicate in writing that you wish to rescind this consent for school health services. As required by law, a new consent form is needed every school year.
- Separate parent/guardian authorizations will be required for the school clinic staff or school staff to administer daily or as needed prescribed or over-the-counter medications, conduct medical procedures or provide medical treatment such as following diabetic and other approved care plans of care.

Healthcare Services: Please check the box below to consent to ALL school-based healthcare services you want your student to receive if/when needed:

☐ I consent to ALL school-based healthcare services as listed below.

Or, if you do not consent to all, please check the boxes below to consent to the individual school-based healthcare services you want your student to receive if/when needed:

Services All screenings are **voluntary, parents/guardians have the right to refuse any or all screenings for their child**	Opt-In	Opt-Out
Care and treatment for illness and/or injury (school clinic services)	☐	☐
Head lice check (if symptoms are evident)	☐	☐
Vision screening (grades KG, 1, 3, 6 only) *will be performed as indicated or performed on any new k-5 student entering the district	☐	☐
Hearing screening (grades KG, 1, 6 only) *will be performed as indicated or performed on any new k-5 student entering the district	☐	☐
Height/weight/BMI screening (grades 1, 3, 6 only)	☐	☐
Scoliosis screening (grade 6 only)	☐	☐

Student Name: _____ ID#: _____ DOB: _____ School: _____

Parent Name (print): _____ Date: _____

Parent Signature: _____ Phone Number: _____

SO-SS-194
Online Only