



Clayton County Public Schools School Health Program

Clayton County Public Schools has established a School Health Program that provides a healthcare technician at your child's school during the school year. If you **choose** for your child to participate in the School Health Program, the healthcare technician/designee must have your permission and some important health information about your child. **Please complete this form and return to the healthcare technician at your child's school.**

Student's Name _____ Date of Birth _____

School _____ Teacher _____ Grade _____

Street Address _____

Parent/Guardian _____ Home Phone _____

Mother's Work Phone _____ Father's Work Phone _____

Mother's Cell Phone _____ Father's Cell Phone _____

Emergency contact #1 _____ Relationship _____

Home Phone _____ Cell phone _____

Emergency contact #2 _____ Relationship _____

Home Phone _____ Cell phone _____

Student's Primary Physician _____ Phone _____

Does your child have any specific health need or chronic health condition? NO _____ Yes (explain) _____

Does your child have an allergy (food, medication, other)? NO _____ Yes (please explain) _____

Does your child take medication daily? NO _____ Yes (please explain) _____

Side effects from medication: _____

The School Health Program provides the services listed below:

- Assessment and evaluation of sudden illness while in school
- Basic First Aid
- Medication Administration (Medication Authorization required)
- Vision, Hearing and Scoliosis Screening
- Health and Nutrition Education
- Referral for illness/injury not suitable for treatment in the school
- Asthma management (Asthma Health Plan and Medication Authorization required)
- Diabetic management/Glucose monitoring (Diabetic Health Plan and Medication Authorization required)
- Seizure management (Seizure Health Plan and Medication Authorization required)
- Allergic Reaction management (Allergic Reaction Health Plan and Medication Authorization required)

If an emergency arises requiring treatment for your child, every effort will be made to contact you immediately. **In the event of the life threatening situation, 911 will be called.** Doctors and hospitals are very conscious of liability suits and will not treat a child without parental consent. Your signature gives us authority to seek emergency medical treatment. **The Clayton County Public School System assumes no financial responsibility for actions taken to preserve the health and well being of the said student.**

I, UNDERSIGNED, HEREBY GIVE THE PERMISSION TO CLAYTON COUNTY PUBLIC SCHOOLS FOR MY CHILD TO PARTICIPATE IN THE ABOVE SERVICES OF THE SCHOOL HEALTH PROGRAM. THE HEALTHCARE TECHNICIAN/DESIGNEE HAS MY PERMISSION TO CONTACT MY CHILD'S PHYSICIAN FOR FURTHER MEDICAL INFORMATION AS NECESSARY. I UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANY TIME BY WRITTEN NOTIFICATION TO THE SCHOOL.

Parent/Guardian Signature _____ Date _____



Student Pick-up Permission Form

I grant permission for the following people to pick up my child from school. I understand that he/she must sign student out and present identification.

Student Name _____

(Parent Name Print)

(Parent Signature)

Date

Name	Name

Mission Statement: To prepare and empower young learners to become highly competent, conscientious, and compassionate global leaders and citizens by means of rigorous instruction, relevant curriculum, and meaningful relationships.