

Check All Health Care Services for which this Consent is Granted:

Physical Examination		Health Screening	
Educational Session(s)		Lab Tests	
Nutrition Education		Asthma Care	

I have had the opportunity to read and fully understand this consent for its content and significance. I agree with the information contained in this consent and confirm that I am the patient or am authorized to sign on the patient's behalf.

Signature of Recipient (Parent or Guardian)

Date

* I understand that as a substitute caregiver to a Chicago Public School student under the legal guardianship of the Illinois Department of Children and Family Services (DCFS) I am not authorized to provide written Consent for Ordinary and Routine Medical and Dental Care. I further understand that I must request consent from the DCFS Guardianship Administrator, or Authorized Agent, and provide a copy of the DCFS Consent for Ordinary and Routine Medical and Dental Care if consent is granted before any of the above services may be provided.