

Medical Permission For School Health Services

Student's Name- _____

Grade- _____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

- 1-Height and Weight
- 2-Vision Screening
- 3-Hearing screening
- 4-Scoliosis screening grades 5 and 7
- 5-BP

I also give permission for my child's medical information to be shared with appropriate teachers if necessary for his/her safety and well being.

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child here at Magnolia through grade 8 and will be incorporated into your child's health record.

If there is a change in permission, written documentation must be provided to the school nurse.

Signature: _____

Date: _____

Printed Name: _____

- Please check this box and sign below if you ***DO NOT*** wish for health screenings to be performed on your child each year.

Signature: _____

Date: _____