

**STUDENTS**

**3500F**

Notice of Health Services

**NOTE: This form is to be provided to students' parents/guardians at the beginning of each school year.**

Dear parent or guardian,

The purpose of this form and the attached copy of the District's policy on Student Health/Physical Screenings/Examinations is to provide notice of all health services offered or made available through the school by the District or by any private organizations and to provide notice of the District's policy on physical examinations and screening of students and to obtain parent/guardian consent for these services.

The District may also provide health care services without parent/guardian consent if District staff reasonably determines that a medical emergency exists:

1. Furnishing the health care service is necessary to prevent death or imminent, irreparable physical injury; or
2. District staff can't contact the parent/guardian despite a reasonably diligent effort and the student's life or health would be seriously endangered by further delay in the furnishing of health care services.

-The District will provide the following additional health services or examinations which can only be provided with parental permission or in the event of an emergency as described above:

Health Service or Exam	Initial to Indicate <b>Permission</b> to Conduct the Health Service or Exam	
Dental	Fall/Spring	
Vision	Fall/Spring	

Speech (K-1)	Fall/Spring	
Student Well-being Assessment (6-12)	Fall/Spring	
Preventative health and wellness services and screenings as described in Policies 2415 and 3500 and associated forms.		
Administering or assisting of the administration of medication as described in Policy 3510		
First aid and emergency care as described in Policy 3540		
<b>Any health services the District deems appropriate</b>		

**Please select one of the following options:**

\_\_\_\_\_ I hereby designate the following emergency contact for my child and grant them authority to consent to health care services provided by the school in the school's absence of ability to reach the me.

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Emergency Contact Email Address: \_\_\_\_\_

\_\_\_\_\_ I do NOT wish to designate an emergency contact to consent to health care services provided by the school in the school's absence of ability to reach me.

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Student Name

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Date

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Parent Signature

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Date

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Parent Name (Printed)

Policy History

Adopted on: August 12, 2024

Revised on:

Reviewed on: