PENNSAUKEN PUBLIC SCHOOLS
SPECIAL SERVICES DEPARTMENT

PERMISSION FOR SCHOOL HEALTH SERVICES

I hereby give permission for my child, _____,
to receive the following medical attention as part of the school health services program in Pennsauken Public Schools:

1. A Mantoux intradermal test for tuberculosis for specified students as mandated by New Jersey Department of Health and Senior Services.

2. Vision, hearing, height and weight screenings according to New Jersey School Health Services Guidelines.

3. Scoliosis screening by the school nurse or certified trained professionals. All students ages 10 through 18 years of age are required to have this exam in New Jersey every other year.

I understand that I will be notified by the school nurse if any problems are found as a result of these screenings.

I give permission for my child to be taken to _____ Hospital for treatment, in case of emergency, if I cannot be reached.

Parent Signature: _____ Date: _____

Address: _____

Telephone: (HOME) _____

(WORK) _____

(EMERGENCY CONTACT) _____