MEDICAL PERMISSION
for
SCHOOL HEALTH SERVICES

Child'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 in 5th and 7th grades
5. Blood.Pressure Screening

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

_____ _____

Parent's Signature **Date**

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child through the 8th grade. It will be incorporated into your child's health records.

You will still be notified before the scoliosis screening and may withdraw permission for any procedure, at any time.