

**PARENT/GUARDIAN WITHHOLD/DECLINE CONSENT FOR SCHOOL HEALTH SERVICES**

School Year 2023-2024

**THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED TO THE SCHOOL NURSE IN ORDER TO WITHHOLD/DECLINE CONSENT FOR ANY SPECIFIC HEALTH SERVICE EACH SCHOOL YEAR**

* In accordance with Florida House Bill 1557, Parental Rights in Education, each school district, at the beginning of the school year, must notify parents/guardians of each health care service offered at their child’s school and provide parents the option to withhold consent or decline any specific service.
* Emergency health needs means onsite evaluation, management, and aid for illness or injury pending the student’s return to the classroom or release to a parent, guardian, designated friend, law enforcement officer, or designated health care provider. There is not an option to withhold/decline consent for emergency health needs (F.S. 381.056; F.S. 768.13).
* Parental/Guardian written consent is required every school year for employees to administer prescribed medication, conduct medical procedures and/or medical treatment. Written consent is also required for The Healthy Student Program, vision and dental programs at participating schools, and specific health services i.e., school entry and sports physicals.

 **Print all information using ink**

**Student Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   |   |   |   |   |  |
| First Name  | Middle Name  | Last Name  | Student Birth Date  | Gender  |  |
|   |   |   |   |   |   |   |   |
| Street Address  |   | Apartment Number  | City  |   | State  |   | Zip Code  |

 **Parent/Guardian Information**

|  |  |  |  |
| --- | --- | --- | --- |
|   |   |   |   |
| First Name  | Middle Name  | Last Name  | Relationship to Student (parent or guardian)  |
|   |   |   |   |   |   |   |
| Street Address  |   | Apartment Number  | City  |   | State  | Zip Code  |
|   |   |   |   |   |
| Home Phone Number  | Work Phone Number  | Cell Phone Number  | Email Address  |  Student ID Number  |

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School Year 2023-2024

|  |  |
| --- | --- |
| **Please indicate below which services you withhold/decline consent.**  | I withhold/decline the healthcare services marked below  |
| Nurse Assessment | ☐  |
| Nutrition Assessment | ☐  |
| Health Counseling | ☐  |
| Referral and Follow-Up of Suspected and Confirmed Health Problems | ☐  |

**\*Annual Health Screenings for Grades KG, 1st, 3rd, and 6th**

Parent/guardian of kindergarten, 1st, 3rd, and 6th grade students receive a separate written notification for scheduled health screenings from their school. At that time, parent/guardian will have the option to decline the state mandated health screening.

Parent/Guardian (PRINT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (SIGNATURE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT’S FIRST & LAST NAME PRINT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

(Must be completed annually)

08.05.2022 ALH