

**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 | |

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

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