

WAKULLA COUNTY SCHOOL BOARD  
PARENT CONSENT FOR STUDENT HEALTH SERVICES  
WHS CLINIC

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please check off which services you would like your child to receive for the 2009/2010 school year:

- Permission to receive ALL CLINIC SERVICES
- Permission to receive ONLY SERVICES CHECKED OFF BELOW
- NO PERMISSION to receive any clinic services

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

- |   |   |
|---|---|
| <input type="checkbox"/> Emergency First Aid                                | <input type="checkbox"/> Hemoglobin (anemia)              |
| <input type="checkbox"/> Immunizations                                      | <input type="checkbox"/> Throat Cultures (strep)          |
| <input type="checkbox"/> Blood Pressure Screening                           | <input type="checkbox"/> Urine Test (bladder, kidney)     |
| <input type="checkbox"/> Minor Illness                                      | <input type="checkbox"/> Sexually Transmitted Infections  |
| <input type="checkbox"/> Health Education                                   | <input type="checkbox"/> Pregnancy Screening              |
| <input type="checkbox"/> Medication   | <input type="checkbox"/> HIV testing and Counseling       |
| <input type="checkbox"/> School Physicals                                   | <input type="checkbox"/> Individual and Family Counseling |
| <input type="checkbox"/> Comprehensive Physical Exam<br>(pelvic, pap smear) | <input type="checkbox"/> Group Counseling                 |
| <input type="checkbox"/> TB skin testing and follow-up                      | <input type="checkbox"/> Mental Health Counseling         |
| <input type="checkbox"/> Communicable Disease Assessment                    | <input type="checkbox"/> Blood Sugar Check (diabetes)     |

All services are rendered by professional staff.  
Students MUST have written parent/guardian permission to receive services.

PLEASE RETURN THIS FORM TO THE WHS CLINIC!!!!!!

Rev. 5/06