



PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES 2020-2021



School: _____ Teacher: _____ Grade: _____

WHAT IS THE SCHOOL HEALTH SERVICES PLAN?

This School Health Services Program is designed to appraise, protect and promote the health of our students as well as provide preventive and emergency school-based health services in accordance with the Whole School, Whole Community, Whole Child (WSCC) model and the School Health Services Plan for Bay County.

BDS SCHOOL HEALTH SERVICES PROGRAM INCLUDES:

The following health care services are provided by the district’s health care partner, PanCare of Florida, Inc. I give consent to the following services (*parents initial items to which you consent*):

Initials: _____ School Health Room Services

- Basic First Aid Services
- Assist student with physician ordered medication administration (BDS permission form required)

Initials: _____ School and Sports Physicals

- Physicals provided by a Florida Licensed Medical Provider

Initials: _____ Preventative Dental Services

- Dental exams provided by a Florida Licensed Dentist
- Dental cleanings provided by a Florida Licensed Dental Hygienist
- Dental sealants applied to molars as needed by a Florida Licensed Dental Hygienist

Initials: _____ TeleHealth/Telemedicine Services

- School health nurse connects student with PanCare (Florida Licensed) Medical Providers during a TeleHealth encounter
- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, influenza, COVID-19, etc.
- If needed, the health care provider can write a prescription and send it electronically to the family’s pharmacy

Initials: _____ Mental and Behavioral Health/Wellness Services

- Counseling, psychiatry, medication management, and therapy

School Health Screenings

Florida Statue 381.0056(7)(d), mandates regular health screenings to public school students. The screenings include vision, hearing, height and weight, Body Mass Index (BMI) and scoliosis (6th grade only). As well as a behavioral health well-being questionnaire for students 12 years & older. **Any parent choosing to decline this required school health screening must provide a written communication to the school administrator.**

PRINT STUDENT’S FIRST AND LAST NAME: _____ **Date of Birth:** _____

PRINT PARENT’S FIRST AND LAST NAME: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ **Date:** _____

The above consent statements will remain in effect until the parent/legal guardian submits a new School Health Services Consent form.