GRADE_____

WINDOW ROCK UNIFIED SCHOOL DISTRICT NO. 8
P.O. BOX 559
Fort Defiance, AZ. 86504

MEDICAL CONSENT

To Parent(s)/ Legal Guardian(s) of Student attending Window Rock USD 8:

It is necessary to have your signature on this medical Consent if you wish your child to be included in the Window Rock USD Health Program. All treatments performed are in compliance with the School Health Laws of the State of Arizona. If there are items below in the consent with which you do not agree, please cross them out in ink. This consent must be renewed every year.

I am legally responsible for _____ DOB_____
(*Name of Student***)**

Census Number_____ Social Security No._____

I give my consent for the following medical care to be administered to the above named child. Care of mild illness and minor injuries by the school nurse, using Standard Basic First Aid procedures.

In case of an emergency, illness or accident, the school is authorized to take the child to the Fort Defiance Public Health Hospital for examination and treatment of other services:

General Health Screening (vision, hearing, etc.)
Personal Hygiene (shower, bathing, brushing of teeth, etc.)
Dental Examination, Fluoride Sealant, and Fluoride Rinse
School Based Teen Health Clinic
Mental Health / Counseling

_____ _____
Print Name of Parent / Legal Guardian ***Signature of Parent / Legal Guardian***

Telephone I can be reached at in case of an emergency_____ _____
Home phone *Business Phone*

Name and telephone number of an adult who can assume responsibility if I CANNOT be reached:

Special Health Problems (vision, hearing, seizures, asthma, diabetes, operations, etc.)

Is your child allergic to anything? (i.e., foods, medications, etc.)

My child can be given Tylenol and / or Ibuprofen for fever or discomfort Yes_____ No_____
My child can be given an Antacid for upset stomach Yes_____ No_____
My child's relative/family member has a history of DIABETES (high Blood Sugar) **Yes_____ No_____**
Please list relationship, i.e., grandfather_____