HIGH POINT REGIONAL HIGH SCHOOL HEALTH OFFICE
MEDICAL PERMISSION/DENIAL FOR SCHOOL HEALTH SERVICES

Student's Name: ____ **DOB:** ____________________

Fall Grade:____ **School Year:**_________________

Listed below are the services that are part of the School Health Program and performed by the Registered Nurse's in the Health Office. Please put a mark (X) to indicate acceptance or denial of these services.

Services Available from the Health Office by Grade:

10th Grade: Height, Weight, Blood Pressure, Vision

11th Grade: Height, Weight, Blood Pressure, Hearing, and Scoliosis

12th Grade: Height, Weight, Blood Pressure

All incoming 9th grade students are required to have a physical dated after their 8th grade graduation date and the results submitted to the nurse's office.

_____**YES**, please perform the appropriate screenings on my child for their grade.

_____I do **NOT wish for my** child to receive any of the above services for this school year and I will have my child examined by their private medical doctor and **provide the school nurse with a copy.**

_____I have submitted a completed **ATHLETIC PARTICIPATION PHYSICAL** form, pursuant to NJAC 6A:162.2.

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Parent/Guardian Printed Name   Signature   Date

IF FORM IS NOT RECEIVED BY the end of present school year
WE WILL PRESUME YOU HAVE GIVEN CONSENT.

Updated 6/2021