Bishop Eustace Preparatory School
New Student Consent/ Release

Student Name: _____

Consent to Release Medical Information

Considering my rights to confidentiality, I understand that some of the medical information submitted on the student's Health History and Physical forms will be utilized to create a Health Profile (i.e. allergies, health conditions, medications) which will accompany them when he/she is involved in a school sponsored activity outside of campus but also to notify necessary faculty/staff of pertinent health information. This information will also be provided to a hospital in an emergency situation. The student's health profile will be updated as additional medical updates are submitted throughout enrollment.

____ I **DENY** consent to release any portion of my child's general health file. **(NOTE: If denied, student may not participate in off campus activities.)**

____ I **CONSENT** to release any necessary health information in my child's health file.

____ I **CONSENT** to release any necessary health information in my child's health file with the exception of: _____.

Please note: In case of emergency, where an ambulance is called, your child will be taken to the nearest hospital. Every attempt will be made to contact you first via the cell/home/work phone numbers provided and then through the emergency contact person(s) that you have provided to us. These names and contact information will be provided to the hospital personnel in the emergency room. Please keep all contact information up to date in myeustace and on the Emergency Contact form filed in the nurse's office.

Consent to Annual Health Screens

Yearly health screenings will be completed by the school nurse according to NJ state requirements. If a physical is submitted by your child's primary care physician, your child may not need to be screened that school year. A notice will be sent home of any deviations from the recommended standards, and you will be asked to follow up with your child's physician. Screenings shall be completed by the school nurse according to NJ State requirements N.J.A.C. 6A:16- 2.2(k). The screenings include vision, hearing, scoliosis, blood pressure, height, and weight.

____ I **CONSENT** to health screenings for my child as scheduled.

____ I **CONSENT** to health screenings for my child as scheduled **EXCEPT** for: _____.

____ I **DENY** consent for all health screening for my child.

_____ _____

Parent/Guardian Signature **Date**