HIGH POINT REGIONAL HIGH SCHOOL
HEALTH OFFICE

MEDICAL PERMISSION/DENIAL FOR SCHOOL HEALTH SERVICES

Must be completed and returned to the School Health Office before end of present school year

Child's Name: _____ Fall Grade: _____

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	**11th Grade**	**12th Grade**
Height	Height	Height
Weight	Weight	Weight
Blood Pressure	Blood Pressure	Blood Pressure
Vision	Scoliosis	
Hearing		

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 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:16-2.2.

Date: _____ Parent/Guardian Signature _____

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