Dear Parent/Guardian/Caregiver

The Departments of Health and Basic Education are providing health services to learners in schools through the Integrated School Health Programme.

For your child to receive these services we need you to give permission by completing the form on the other side of this page.

The school health services MAY include the following:

1. Checking your child’s health (body, eyes, ears, teeth, mental health, TB and other conditions)
2. Deworming (Grades R – 7)
3. Immunisation (against measles, polio, tetanus and diphtheria)
4. Treatment for common health problems if needed (worms, scabies, lice)
5. Health education
6. Immunisation against the virus (HPV) which causes cervical cancer (Grade 4 girls 9 years and older).

You can come with your child to school on the day when the health team visit. You will be informed if your child needs to be referred for any other services.

Please contact the School Principal for any inquiries or additional information about these services or if you have given permission and you want to change your mind.

Please return the completed form to the school as soon as possible.

Yours sincerely

__________________________
Principal’s signature

__________________________
Principal’s name and surname

__________________________
Date

__________________________
Name of School:

__________________________
School Tel:

(school stamp)
 wildfire

PERMISSION/CONSENT FORM: SCHOOL HEALTH SERVICES

Parent/Guardian/Caregiver please COMPLETE the information on this form.

Name of Learner: __________________________ Grade: __________

Date of birth: __________________________ Age: __________

A. IF YOU WANT YOUR CHILD TO RECEIVE SCHOOL HEALTH SERVICES COMPLETE THIS SECTION

I __________________________ give permission for my
(name and surname of parent/guardian/care giver)

child __________________________
(name and surname of child)

to receive ALL school health services at any time during the school year.

Signature: Parent/guardian/caregiver __________________________ Date __________

B. IF YOU WANT YOUR CHILD TO RECEIVE ONLY SOME SCHOOL HEALTH SERVICES COMPLETE THIS SECTION (Tick the box next to the services you want your child to receive)

☐ Immunisation against the virus (HPV) which causes cervical cancer ONLY for Grade 4 girls 9-yrs and older
☐ Deworming
☐ Health Check (body, eyes, ears, teeth, mental health, TB and other conditions)
☐ Immunisation (Measles, Polio, Td)
☐ Treatment for common health problems

Signature: Parent/guardian/caregiver __________________________ Date __________

C. THIS SECTION MUST BE COMPLETED

Does your child have any health problems?
☐ No ☐ Yes ☐ Don’t know
If Yes what is the problem?
____________________________________________________________

If yes: Is your child receiving treatment for the health problem?
☐ No ☐ Yes ☐ Don’t know

Do you have a household member with TB?
☐ No ☐ Yes

Does your child have any allergies?
☐ No ☐ Yes ☐ Don’t know
If Yes what is your child allergic to?
____________________________________________________________

Has your child received their 6 year old vaccination?
☐ No ☐ Yes ☐ Don’t know