School Health Risk Assessment Consent Form

Student Information

Full Name

Date of Birth

Grade

Parent/Guardian Information

Parent/Guardian Name

Contact Number

Email Address

Assessment Information

Type of Assessment

☐ Vision ☐ Hearing ☐ Dental ☐ Other

If Other, please specify

Medical History

Please list any relevant medical conditions or allergies

Consent

☐ I consent to my child participating in the school health risk assessment. I understand that the results will be kept confidential and used for school health purposes only.

Parent/Guardian Signature

Date