Phoenix Central School District
Phoenix. NY 13135

PARENT CONSENT FORM

Student Name: ______________________________________

Student ID #: ______________________________________

Grade: ______________________________________

School: ______________________________________

Authorization of Care by School Physician

I, ____________________________________ (**PLEASE CHECK ONE**) ___ DO___ DO NOT authorize the
(Parent or Legal Guardian)

designated School Physician/Nurse Practitioner to complete a physical examination of ______________________,
(Student)

as per school policy and as required by New York State Department of Education Laws. This consent is valid indefinitely

from this date ____________________, unless revoked by parent/guardian, or if the parent/guardian of student changes.

It is the parent/guardian responsibility to notify the school district of this change in guardianship.

Permission for School Physician to contact student's doctor if medically necessary:

(*Check One Please*) **yes** **no**

The school nurse has my permission to contact my child's doctor if medically necessary:

(*Check One Please*) **yes** **no**

Parent or Legal Guardian Signature: ____

Date: __________________________