

**SHS 1a**

**INTEGRATED**

**SCHOOL HEALTH PROGRAMME**

**CONSENT FORM**

**GRADES R TO 7**

Dear Parent/Guardian/Caregiver

The Departments of Health, Basic Education and Social Development provide 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 completeing 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) (one tablet, that is swallowed)
3. Immunisation (against measles, polio, tetanus and diphtheria)
4. Immunisation against the virus (HPV) which causes cervical cancer (Grade 4 girls, nine years and older).
5. Treatment for common health problems if needed (worms, scabies, lice)
6. Health education

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

Please contact the school principal for any enquiries 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.**

**Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Tel:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(school stamp)**

**PERMISSION/CONSENT FORM: SCHOOL HEALTH SERVICES**

Parent/guardian/caregiver please **COMPLETE** the information on this form

Name of learner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **IF YOU WANT YOUR CHILD TO RECEIVE ALL SCHOOL HEALTH SERVICES, COMPLETE THIS SECTION** |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**give permission** for my child to receive **ALL**

Name: parent/guardian/caregiver

school health services at any time during the school year

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: Parent/guardian/caregiver AND/OR Signature: Child that is 12yrs & older**

**Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| 1. **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)**   I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**give permission** for my child to receive the following:  Name: parent/guardian/caregiver   * Immunisation against the virus **(HPV)** which causes cervical cancer ONLY for **Grade 4 girls nine years and older** * Deworming * Health check (body, eyes, ears, teeth, mental health, TB and other conditions) * Immunisation * Treatment for common health problems |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Parent/guardian/caregiver AND/OR Signature: Child that is 12yrs & older**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| 1. **THIS SECTION MUST BE COMPLETED** | |
| **Does your child have any health problems?**  🞏 No 🞏 Yes Do not know 🞏  **If yes: Is your child receiving treatment for the health problem?**  🞏 No 🞏 Yes Do not know 🞏  **Do you have a household member with TB?**  🞏No 🞏Yes | **Does your child have any allergies?**  🞏 No 🞏 Yes Do not know 🞏  If **yes** what is your child allergic to?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Has your child received their six-year-old vaccination?**  🞏 No 🞏 Yes Do not know 🞏 |