Fulton City School District

SCHOOL PHYSICAL CONSENT FORM

Student Name _____ Date of Birth _____

School _____ Grade _____

Please check the appropriate box. Sign and return to the school nurse.

☐ I give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws.

☐ I do **NOT** give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws. I will have a physical completed by our family physician.

This consent is valid from this date unless revoked by the parent or guardian. If custody or guardianship changes in the future, it is the responsibility of the parent or guardian to notify the school district of such a change.

_____ _____

Signature Parent/Guardian Date