Clark County Public Health Department

997 N York St, Martinsville, IL 62442
Phone: (217) 382-4207 ~ FAX: (217) 382-4226
http://www.clarkhd.org

CHILD HEALTH CONSENT

Address____City/State________________________
Home/Cell Phone____Physician____________________

Email Address____

I, __________________________________ give permission to the Clark County

(Print Parent or Guardian's Name)

Health Department to provide the following for ________________________________

(Print Child's Name)

(Child's DOB:________________):

1. **NECESSARY EXAMINATIONS:**
   - Physical Assessments
   - Height
   - Weight
   - Other Measurements as needed
2. **LAB TESTING:**
   - Hemoglobin
   - Lead Screening
   - Other (ex: Diabetes Screening)______________________
3. Contact physician in regards to health records and any abnormal findings at WIC appointments.
4. Developmental Screening
5. I am authorizing the <u>release of Immunization records</u> to my child's pre-school, elementary, and high school and to other persons or entities named below. This information may be given either verbally, by fax or by mail. This consent of release of Immunization records is valid until my child attains 18 years of age. I understand that I may revoke this request by giving <u>written notice</u> to the health department.
6.
   1.____________________________________ 2.____________________________________

   3. ____________________________________ 4. ____________________________________
7. What Insurance Carrier do you have: _____________ _____________
   Primary *Secondary*

(Circle one) **Not Hispanic or Latino/ OR/Hispanic of Latino**

(Circle one) **Asian, American Indian/Alaska Native, Black or African American, Native Hawaiian/ Other/ Pacific Islander, White**

Signature____(Parent or Guardian)

Witnessed by ____(CCHD Employee)

Date ____________________________