Clark County
Health Department

P. O. Box 266
Martinsville, IL 62442
217-382-4207 Phone
217-382-4226 Fax

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 release of Immunization records 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 written notice to the health department.

   1.________________________________ 2.________________________________

   3. ________________________________ 4. ________________________________

6. What Insurance Carrier do you have: ______________ ______________
   Primary Secondary

Signature____(Parent or Guardian)

Witnessed by ____(CCHD Employee)

Date ______________________________

This institution is an equal opportunity provider.