Tri-Area Community Health

School Based Health Center Consent Form

Student's Name: _____**Date of Birth**: _____**SSN**: _____
School: _____ **Grade**: _____

Medical Care

Services Provided:

- Physical exams for school, sports & camp
- Treatment for acute & chronic illness & injuries
- Vision/hearing screenings and follow-up
- Referrals for specialty services
- Basic laboratory services & tests

I consent for my child to receive medical care through the School Based Health Center.
Does your child have health insurance? Y / N
Medical Insurance (choose one):
Medicaid #/Insurance: _____
Insured: _____
Name of insured parent, insurance name and policy #

Where do you take your child to see the doctor? _____
Phone #: _____ Date of last physical exam: _____
List of allergies to medicines, foods, bee stings, etc.: _____
If yes, does your child require an Epi-Pen? Y / N
List of current medications, dosage, and time taken: _____
_____ Pharmacy: _____
Does the child have any medical problems including learning/physical disabilities? Y / N If yes, please list.
_____
Does the child's siblings or parents have any medical problems? Y / N. If yes, please list. _____
_____
Has your child ever had any surgeries? Y / N If yes, describe: _____

What language is most often spoken at your home? _____
Is there any other important health information we should know? _____
_____
Would you like to request any other assistance, or have any comments to help the health center serve you better?
_____

May we leave a voicemail with NEGATIVE testing results? _____YES _____NO_____

PLEASE SIGN ON THE REVERSE SIDE

Parent/Guardian Information

Mother/Guardian: _____ DOB: _____ Home/Work Phone: _____
Father/Guardian: _____ DOB: _____Home/Work Phone: _____
Parent/Guardian address: _____
Email address: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

Authorization for Disclosure of Information

Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (HPI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services and on the Tri-Area Community Health (TACH) website.

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school, the health department, and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include, but is not limited to the following; immunizations records, class schedules, parental/guardian contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed.

I understand that if my child requires the School Based Health Services, reasonable attempts will be made to contact me and if I cannot be reached, I give consent for my child to be seen by the providers at the clinic.

I hereby authorize the School Based Health Center to provide the services as indicated above. I authorize TACH to file my insurance for services rendered. I request that payment be made directly to TACH. I understand that I am responsible for all charges incurred regardless of my insurance status or lack thereof. Slide fee applications are available at www.triareahealth.org.

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

_____

Parent/Guardian Signature **Date**