NAME_____
SCHOOL_____
TEACHER_____ GRADE_____

CONSENT FORM

In order for your child to receive services with [Insert Medical Sponsor] at [Insert School Name], this consent form must be completed and proper documentation of insurance obtained. Please complete all sides of this consent form. Please initial the area for acknowledgment of receiving the clinics' Notice of Privacy Policies.

I hereby voluntarily give my consent for _____ to receive the health,

Name of Child

services with [Insert Medical Sponsor] at [Insert School Name]. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care.

I understand that my signing this consent allows the physician and professional clinic staff of [Insert Medical Sponsor] at [Insert School Name] to provide comprehensive health services which includes physical, behavioral and dental health services. I authorize periodic dental examinations for my child, which may include photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child's dental health.

I authorize release of information from my son or daughter's medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services. I also authorize the Clinic to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale**. No patients will be denied services because of inability to pay.**

Finally, I give consent to share my child's health information between the school nurse and the school based health center in order to obtain information needed to provide the best healthcare possible.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at **[Insert Phone Number]**. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

_____	_____	_____
Name of Patient (PLEASE PRINT)	**Date of Birth**	**Date**
_____	_____	_____
Parent or Legal Guardian (PLEASE PRINT)	**Parent or Legal Guardian (PLEASE SIGN)**	**Date**

Revised 5/10/17

NAME_____
SCHOOL_____
TEACHER_____ **GRADE**_____

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order for your child to receive services from the Health Clinic. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Date: _____

Patient's Name_____ _____ _____
First Middle Last

Date of Birth _____ Social Security Number_____-_____-_____ Sex_____ Race_____

Primary Language _____ Remedial/Special Education Yes No

Marital Status: Married Single Widowed Divorced Separated Unknown

Consent to receive texts? Yes or no Consent to access the Patient Portal? Yes or No Email Address_____

Home Phone #_____ Cell Phone # _____ Work Phone # _____

Address_____Apt.#_____

City _____ State _____ Zip _____ Birth Country _____

How long at present address? ____Years ____Months How long at previous address? _____Years _____Months

Is present housing: ____Permanent___ Temporary _____ Shelter _____ Institution _____None ____Unstable ____Foster Care ____Other

Who lives with student: Please list everyone who lives in home including yourself:

NAME	RELATIONSHIP	AGE

Does anyone in the home smoke cigarettes or use tobacco products? Yes or No

Emergency Contact Name _____ Relationship to Patient_____
Phone Number _____
Next of Kin Name _____ Relationship to Patient_____
Phone Number _____

==========

WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE?

PLEASE PROVIDE PROOF OF INSURANCE OR YOU MAY BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. PLEASE LIST ALL INSURANCE COVERAGE THE CHILD IS ELIGIBLE FOR.

Name of Policy Holder/Guarantor _____ Date of Birth _____ Relationship to Patient_____

Name of Insurance _____Policy #_____ Group #_____

Insurance Address_____

Secondary Insurance Name _____ Policy # _____ Group#_____

Insurance Address_____

_____No Insurance

You may be eligible for free insurance. Would you be interested in someone contacting you regarding this "free" insurance? Yes or No

Revised 5/10/17

NAME_____
SCHOOL_____
TEACHER_____ **GRADE**_____

General History

Does the patient have any allergies to medications, food and /or anything else?
List here _____Reactions _____

Please List Daily Medication Names and Dosages

_____

_____

Pharmacy Name _____ Phone Number _____

Any Health Problems Under Treatment? ___ Yes ___No, if yes explain _____

Specify where treatment was received? _____

Has your child seen a doctor in the last year? _____Yes ____No
If yes, how many time? Circle: 1 time 2 times 3 times 4 or more times

Where? _____

Why? _____

Has your child used a Hospital Emergency Room in the last year? ____Yes ____No
If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times

Where? _____

Why? _____

Was your child in the hospital overnight in the last year? ____Yes ____No

Where? _____

Why? _____How Long_____

Where do you take your child for Primary care/Routine care and Acute care/Emergency/Sick visits? In the columns below check the ones that apply and fill in names, addresses and phone numbers.

	PRIVATE DOCTOR OR CLINIC	**HOSPITAL OUTPATIENT CLINIC**	**NAME / ADDRESS/ PHONE NUMBER**
PRIMARY CARE/ROUTINE CARE			
ACUTE CARE EMERGENCY SICK VISITS			

Family History

Please specify who has or had any disease listed below by using abbreviations below.
(Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)

	WHO		**WHO**
Asthma	_____	Heart Trouble	_____
Allergies	_____	High Blood Pressure	_____
Birth Defects	_____	Kidney/Bladder Problems	_____
Blood Disorders/Anemia	_____	Lung Diseases	_____
Cancer	_____	Tuberculosis	_____
Tumors	_____	Seizures	_____
Cystic Fibrosis	_____	Mental Retardation/Illness	_____
Diabetes (before 40)	_____	Muscle Disease/Weakness	_____
Early Childhood Death	_____	Death Under Age 50	_____
Ear/Eye Disorders	_____	There is no family history of the above Diseases?	_____

NAME_____
SCHOOL_____
TEACHER_____ GRADE_____

CHILD'S MEDICAL HISTORY

ILLNESS HISTORY

Allergies	__Yes __No
Allergic to drugs	__Yes __No
Anemia	__Yes __No
Asthma	__Yes __No
Other Respiratory Problems	__Yes __No
Stomach Ulcers	__Yes __No
Abdominal Pain	__Yes __No
Constipation/Diarrhea	__Yes __No
Serious Digestive Problems	__Yes __No
Chicken Pox Age____	__Yes __No
Ear Problem	__Yes __No
Ear Infections	__Yes __No
Hearing Aid	__Yes __No
Eye Problem	__Yes __No
Wears Glasses	__Yes __No
Physical/Sexual Abuse	__Yes __No
Fainting Spells/Knocked Out	__Yes __No
Frequent Sore Throat	__Yes __No
Headaches	__Yes __No
Heart Murmur	__Yes __No
Heart Problems	__Yes __No
High Blood Pressure	__Yes __No
Thyroid Problems	__Yes __No
Diabetes	__Yes __No
Hepatitis	__Yes __No
Injuries (major)	__Yes __No
Musculoskeletal Problems	__Yes __No
Broken Bones	__Yes __No
Problems Walking	__Yes __No
Kidney/Urinary Tract Problems	__Yes __No
Frequent Colds	__Yes __No
Lung Problems	__Yes __No
Meningitis	__Yes __No
Menstruation Started Age_____	__Yes __No
Menstrual Problems	__Yes __No
Premature Birth Weight_____	__Yes __No
Obese	__Yes __No
Skin Rashes	__Yes __No
Serious Acne	__Yes __No
Sickle Cell Disease	__Yes __No
Sickle Cell Trait	__Yes __No
Other Blood Disorders	__Yes __No
Seizures/Epilepsy	__Yes __No
Speech Problem	__Yes __No
Tuberculosis	__Yes __No
Cancer	__Yes __No
Other_____	__Yes __No

BEHAVIOR HEALTH

Eating Problems	__Yes __No
Thumb Sucking	__Yes __No

BEHAVIOR HEALTH (Cont'd)

Nightmares	__Yes __No
Bedwetting	__Yes __No
Discipline Problems	__Yes __No
Overactive/Hyperactive	__Yes __No
Shy	__Yes __No
Sleeping Problems	__Yes __No
Slow Development	__Yes __No
Learning Disability	__Yes __No
Smoker	__Yes __No
Alcohol	__Yes __No
Inhalants	__Yes __No
Other Drugs _____	__Yes __No
Depression	__Yes __No
Other Behavior Problems	__Yes __No
Other Mental Problems	__Yes __No
Other_____	__Yea __No

Explain any behavior or mental problems noted _____
_____
_____

PLEASE LIST ANY PRESENT CONCERNS:
_____
_____
_____

***Explain any illnesses marked yes:
_____
_____
_____
_____

DENTAL

Dental Problems	__Yes __No
Pregnant	__Yes __No
AIDS/HIV	__Yes __No
Rheumatic Fever	__Yes __No
Hemophilia	__Yes __No
Underweight	__Yes __No

When was your child's last dental visit?
_____

How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? _Yes _No

Has your child had any injury to the teeth or jaws? __Yes __No

Does your child have a finger or thumb sucking habit?

Generally speaking, what has been your child's experience with a dentist? __Good __Bad __Very Bad
__No experience (the child's first visit)

Revised 5/10/17

NAME_____
SCHOOL_____
TEACHER_____ GRADE_____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other relatives_____
[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call
[ ] my home _____
[ ] my work_____
[ ] my cell number:_____
[ ] other number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other _____

The best day to reach me is _____between_____ am/pm & _____am/pm
Signed: _____ Date: _____/_____/_____
Witness: _____ Date: _____/_____/_____

I understand the **[Insert Medical Sponsor] at [Insert School Name]** is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations. If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness. I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I HAVE RECEIVED THE [Insert Medical Sponsor] at [Insert School Name] SCHOOL HEALTH CLINICS NOTICE OF PRIVACY PRACTICES.

_____ _____

NAME_____

SCHOOL_____

TEACHER_____ GRADE_____

(PLEASE INITIAL) **(DATE)**