School Based Health Consent for Services
Grace Community Health Center, Inc.

Please read carefully: In order for us to see your child in school based clinics, all pages of this form must be completed by the child's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their teacher or nurses' station. Consent is for the 2016-17 school year and may be withdrawn at any time.

Child's School:_____

_____ _____ _____
Student's Last Name First Name/ Middle Initial Date of Birth

Social Security Number: _____ Gender: ___Male ___Female

Race: ___American Indian or Alaska Native ___Asian ___Black or African American
___ Native Hawaiian or Other Pacific Islander ___White

Ethnicity: Are you Hispanic or Latino? ___Yes ___No
Primary Language: _____ Religion Preference: (optional) _____

Address: _____
City _____ State _____ Zip Code _____

Physical Address (If Mailing Address is a P.O. Box):
_____

Home / Cell Phone Number: _____

In Case of Emergency Please Contact:
Name of Mother/ Legal Guardian_____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

Name of Father/ Legal Guardian: _____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

If Immediate Family is Not Available, Please Contact:

Name and Relationship to Child: _____

_____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number

Student's Medical History

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

___ Measles
___ Mumps
___ Anemia
___ Birth Defects
___ Diabetes
___ Chicken Pox
___ Rheumatic Fever
___ Asthma
___ Sleep Problems
___ Scarlet Fever
___ Seizures
___ Unexplained Weight Loss
___ Unexplained Tiredness
___ Persistent Cough
___ Unexplained Weight Gain
___ Leukemia
___Stomach or Bowel Problems
___ Joint or Muscle Pain or Stiffness
___ Exposed to Tuberculosis
___ Shortness of Breath
___ Head, Eyes, Ears, Throat Problems
___ Blood Transfusions
___ Anaphylactic Episodes
___ Chest Pain

If you answered yes to any of the above, please explain: _____
_____

Student's Medications taken on a regular basis: _____
****You will be asked to complete a separate Medication Consent form if you desire the School Nurse to administer this medication in the School.**

Student's doctor: _____ Address: _____
Student's dentist: _____ Address: _____
Student's Pharmacy: _____ Address: _____
___ Any Operations (reason/date):_____
___ Any Hospitalizations (reason / date): _____
___ Any serious injuries or illnesses (describe): _____

When was the last time your child was seen by a doctor?

_____
Doctor's Name Reason Date

Student's allergy to FOOD, MEDICATIONS, OR ENVIRONMENTAL POLLENS? Yes No
IF YES, PLEASE LIST: _____

Have there been any recent upsets in the family that might affect your child? ___Yes ___No
If you answered yes please explain: _____

Family Medical History:

Please check the appropriate space if any of the child's blood relatives(mother, father, brother, sister) has any of the following conditions.

_____HIV/AIDS
_____Alcohol/Drug Addiction
___ __Alzhemier's
___ __Arthritis
_____ Asthma
_____ Birth Defects
_____ Bleeding Disorders
_____ Cancer
_____ COPD/Emphysema/Bronchitis
_____ Diabetes
_____Epilepsy/Seizures
_____ Heart Attack/Stroke
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease
_____ Liver Disease/Hepatitis
_____Mental Illness
_____Osteoporosis
_____Sickle Cell
_____ Thyroid Disorder
_____Tuberculosis/TB
_____Other:

Immunization Status:

Is your child up to date on immunizations? ___Yes ___No

Where is the child's immunization record on file: _____
___Yes, I give permission for school nurse to request a copy of immunization record

Other:
Do you have concerns about your child's health? ___Yes ___No
Is your child exposed to second hand smoke? ___Yes ___No
Does your child smoke and/or use tobacco products? ___Yes ___No
Does your child drink alcohol? ___Yes ___No

The following list of medications will be on hand at the Satellite School Clinic to be administered by the School Nurse after she has evaluated your child's complaint.

Acetaminophen (Generic name for Tylenol)	Ibuprofen (Generic name for Advil)
Claritin for allergies	Orajel/ Orasol
Refresh Plus Eye Drops/ Refresh	Zofran for nausea
Tums for indigestion	Triple antibiotic ointment
Diphenhydramine (Generic for Benadryl)	Hydrocortisone 1% Cream
Tussin DM	Hydrogen Peroxide (for wound cleansing)
Solarcaine spray for burns and scrapes	Simethicone for gas
Immodium for diarrhea	

If you prefer we do not administer a drug listed above please list below.

INCOME ***Note: Grace Community Health Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Family Size	**Annual Income (please circle one)**			
1	**Below $11,770**	**$11,771-17,655**	**$17,656-23,540**	**Above $23,540**
2	**Below $15,930**	**$15,931-23,895**	**$23,896-31,860**	**Above $31,860**
3	**Below $20.090**	**$20,091-30,135**	**$30,136-40,180**	**Above $40,180**
4	**Below $24,250**	**$24,251-36,375**	**$36,376-48,500**	**Above $48,500**
5	**Below $28,410**	**$28,411-42,615**	**$42,616-56,820**	**Above $56,820**
6	**Below $32,570**	**$32,571-48,855**	**$48,856-65-140**	**Above $65,140**

Please complete the following insurance information for your student. This information is **required** for the students health record to be complete but will ONLY be billed if services are provided the by Nurse Practitioner. School nurse visits are not billed to insurance.

Medical Card/Managed Care Organization (MCOs)
Insurance Company: _____ Policy Number: _____
Health Insurance- Please Fully Complete and Please attach copy of insurance card
Insurance Company: _____ Policy Number: _____
Group Number: _____
Send Medical Claims to Address on Card: _____
Name on Insurance Card: _____
Policy Holder Information:
Name of Primary Insured (policy holder): _____
Relationship to Patient: _____
Social Security Number of Primary Insured (policy holder): _____
Gender: _____ Policy Holder's Date of Birth:_____
Mailing Address: _____

Grace Community Health Center School Based Health

Assignment of Benefits / Consent for Treatment

I consent to the customary tests (ie. blood glucose testing), procedures that may be deemed necessary for treatment of my child's condition by Nurses (RN) and Family Nurse Practitioners members of the Medical Staff and Employees of Grace Community Health Center. Consent is hereby given for such visits to the school nurse, examination, treatment, and procedures.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment.

I authorize payment of medical benefits to the supplier for services provided by Grace Community Health Center.

I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. ***Visits to the school nurse are not billed**.

Authorize for Release of Medical Information for Billing Purpose Only

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release Grace Community Health Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

_____ _____

Date **Signature of the Parent/Legal Guardian**

_____ _____

Best **phone number** to reach you **Email** to link you to Patient Portal for child's health record

_____ _____

Date Signature of Witness

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

_____

Date Phone Number Witness Name Address

_____

Date Phone Number Witness Name Address

CONSENT FOR WELL-CHILD EXAMS

As part of overall health care for children, the school requires Kindergarten and 6th Grade Well Child Exams and it is recommended that all children have a Well Child Exam on a yearly basis. The Nurse Practitioner can complete the exam if you want to get your child's check-up through the school clinic. **All you need to do is sign below giving permission if you would like us to complete your child's Well Child Exam or School Grade Entry Exam.**

If your child has already had a well-child exam or the required school check-up at their primary care physician's office, please forward a copy of it to the school as soon as possible. Well Child exams are billable and will be billed to your insurance/medical card. Although, for private insurance NO COPAY will be billed to you because the children's well-child exams are covered 100% by insurance. So it will be **NO COST** to you.

All of the exam can be completed at the school clinic EXCEPT for any required immunizations (shots) because we are not able to bring the vaccines to school. **If your child needs a physical that requires vaccination,** the school nurse will help you schedule an appointment with your child's physician or the health department.

____**Yes**, I would like for Grace Community to complete my child's exam at school.

____My child has already had their required school exam or the well-child exam.

Parent/Guardian Signature:_____

Best Phone Number to reach you: _____