AccessHealth

PARENT CONSENT FORM
INFORMED CONSENT FOR
SCHOOL-BASED HEALTH SERVICES

Because young adolescents go through rapid physical and emotional changes, have significant risks to their health, and have problems getting to health services, the following services are provided at the school-based health center:

PHYSICAL EXAMS AND SPORTS PHYSICALS / HEALTH CARE FOR ILLNESSES & INJURIES
MANAGEMENT FOR LONG TERM ILLNESSES / MEDICALLY-PRESCRIBED LABORATORY TESTS
HEALTH EDUCATION FOR STUDENTS AND PARENTS / IMMUNIZATIONS
VISION SERVICES BY REFERRAL / REFERRAL FOR SPECIALTY CARE
BEHAVIORAL HEALTH SERVICES

If you want your child to receive services at the health center, please read this form carefully, complete the questions, and sign.

CHILD

NAME: (PLEASE LIST CHILD'S NAME AS IT APPEARS ON BIRTH CERTIFICATE) ____________ BIRTH DATE: ________ GRADE: ________ SEX: MALE FEMALE

SOCIAL SECURITY NUMBER: ________ RACE: WHITE BLACK OTHER ________ DOES YOUR CHILD QUALIFY FOR FREE/REDUCED LUNCH? YES NO

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS (PHYSICAL HANDICAP, LEARNING DISABILITIES, DIETARY NEEDS, ETC)? YES NO IF YES, WHAT ________

PARENT/GUARDIAN (THE PERSON WITH LEGAL RIGHT TO MAKE HEALTHCARE DECISIONS FOR THE PATIENT/STUDENT)

NAME: ____________ RELATIONSHIP TO CHILD: ________ BIRTH DATE: ________

MAILING ADDRESS: ________ CITY, STATE, ZIP ________ SOCIAL SECURITY NUMBER: ________

HOME PHONE NUMBER: ________ CELL PHONE NUMBER: ________ WORK PHONE NUMBER: ________

EMERGENCY CONTACT (NOT FOR MEDICAL DECISION MAKING)

PLEASE LIST AN ADULT RELATIVE OR FRIEND THAT WILL KNOW HOW TO CONTACT YOU IN CASE OF AN EMERGENCY

NAME: ________ RELATIONSHIP TO CHILD: ________ PHONE NUMBER: ________

AccessHealth

PARENT CONSENT FORM
INFORMED CONSENT FOR
SCHOOL-BASED HEALTH SERVICES

The following information will help the healthcare provider evaluate your child's health.
Please answer to the best of your knowledge.

ALLERGIES

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? YES NO IF YES, WHAT?

DOES YOUR CHILD HAVE ANY OTHER ALLERGIES? (SUCH AS FOODS, POLLENS, INSECT BITES, ETC) YES NO IF YES, WHAT?

MEDICATIONS

LIST ANY MEDICATIONS YOUR CHILD IS TAKING NOW AND REASON FOR WHICH THE MEDICINE WAS GIVEN

MEDICATION/DOSE	REASON	HOW LONG TAKING MEDICATION
MEDICATION/DOSE	REASON	HOW LONG TAKING MEDICATION
MEDICATION/DOSE	REASON	HOW LONG TAKING MEDICATION

HISTORY

HAS YOUR CHILD EVER HAD ANY SERIOUS OR SPORTS RELATED INJURIES OR BEEN HOSPITALIZED OVERNIGHT? YES NO IF YES, EXPLAIN

HAS THERE BEEN ANY CHANGE IN YOUR CHILD'S HEALTH DURING THE PAST YEAR? YES NO IF YES, GIVE THE AGE AND EXPLAIN

HAS YOUR CHILD EVER RECEIVED MENTAL HEALTH COUNSELING SERVICES? YES NO IF YES, WHEN AND WITH WHOM

HISTORY

PLEASE CHECK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS AND STATE AT WHAT AGE THE PROBLEM STARTED

YES	AGE		YES	AGE		YES	AGE	
	____	ALLERGIES		____	ENDOCRINE/GLAND DISEASE		____	SEIZURES
	____	ANEMIA OR BLOOD DISORDERS		____	HEPATITIS		____	SEVERE ACNE
	____	ASTHMA		____	HEADACHES/MIGRAINES		____	SPORTS INJURIES OR FRACTURES
	____	BLADDER OR KIDNEY INFECTIONS		____	MONONUCLEOSIS		____	THYROID DISEASE
	____	CANCER		____	PNEUMONIA		____	TUBERCULOSIS
	____	CHICKEN POX		____	RHEUMATIC FEVER/HEART DISEASE		____	ULCER OR DIGESTIVE PROBLEMS
	____	DIABETES		____	SCOLIOSIS		____	MENTAL ILLNESS OR DEPRESSION
	____	OTHER						

IMMUNIZATIONS

WHEN WAS YOUR CHILD'S LAST DPT OR TETANUS SHOT? (MONTH/YEAR)

LAST MEASLES, MUMPS, RUBELLA (MMR)? (MONTH/YEAR)

HAS YOUR CHILD BEEN VACCINATED AGAINST HEPATITIS B?
(PLEASE NOTE THIS IS NOT THE "HIB" VACCINE.) YES NO

1ST 2ND 3RD

IF YES, PLEASE INDICATE APPROXIMATE DATES (MONTH/YEAR)

** PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD **

FAMILY

PLEASE CHECK IF YOU OR ANY OF YOUR CHILD'S BLOOD RELATIVES (PARENTS, GRANDPARENTS, AUNTS, UNCLES, BROTHERS OR SISTERS), LIVING OR DECEASED, HAD ANY OF THE FOLLOWING PROBLEMS. PLEASE STATE THE RELATIVE'S RELATIONSHIP TO YOUR CHILD.

YES	RELATIONSHIP		YES	RELATIONSHIP	
	______________	ALCOHOLISM/DRUGS		______________	HIGH CHOLESTEROL
	______________	ALLERGIES/ASTHMA		______________	HIGH BLOOD PRESSURE
	______________	ARTHRITIS		______________	KIDNEY DISEASE
	______________	BIRTH DEFECTS		______________	LUNG DISEASE/TUBERCULOSIS
	______________	BLOOD DISORDERS/SICKLE CELL ANEMIA		______________	MENTAL HEALTH/DEPRESSION
	______________	CANCER (TYPE ______________________)		______________	MENTAL RETARDATION
	______________	DIABETES		______________	OBESITY
	______________	ENDOCRINE/GLAND DISEASE		______________	SEIZURES/EPILEPSY
	______________	HEART ATTACK		______________	STROKE BEFORE AGE 55

WITH WHOM DOES THE ADOLESCENT LIVE MOST OF THE TIME? CHECK ALL THAT APPLY

BOTH PARENTS IN SAME HOUSEHOLD	MOTHER	FATHER
STEPFATHER	STEPMOTHER	BROTHER(S)/AGES: ______________
GUARDIAN	ALONE	SISTER(S)/AGES: ______________
OTHER: ______________________		

IN THE PAST YEAR, HAVE THERE BEEN ANY CHANGES IN YOUR FAMILY SUCH AS:

MARRIAGE	SERIOUS ILLNESS	MOVED TO A NEW HOME
SEPARATION	LOSS OF JOB	DIVORCE
DEATHS	CHANGE IN SCHOOL	OTHER: ______________________

ARE THERE SMOKERS IN YOUR HOUSE? YES NO

AccessHealth

MEDICAL PROVIDERS

CHILD'S DENTIST NAME:	WHEN WAS YOUR CHILD'S LAST DENTAL EXAM?
CHILD'S FAMILY DOCTOR OR PEDIATRICIAN NAME:	WHEN WAS YOUR CHILD'S LAST COMPLETE PHYSICAL EXAM?

IF WE NEED TO CALL IN A PRESCRIPTION FOR YOUR CHILD, WHICH PHARMACY WOULD YOU LIKE US TO CALL?

QUESTIONS & CONCERNS

SOME PARENTS OR GUARDIANS HAVE QUESTIONS OR CONCERNS ABOUT THEIR CHILD'S DEVELOPMENT. PLEASE REVIEW THE TOPICS LISTED BELOW AND CHECK ANY CONCERNS YOU MAY HAVE ABOUT YOUR SON OR DAUGHTER

- PHYSICAL COMPLAINTS
- PHYSICAL DEVELOPMENT
- WEIGHT
- CHANGE OF APPETITE
- SLEEP PATERNS
- DIET NUTRITION
- AMOUNT OF PHYSICAL ACTIVITY
- EMOTIONAL DEVELOPMENT
- RELATIONSHIPS WITH FAMILY MEMBERS
- CHOICE OF FRIENDS
- SELF-IMAGE/SELF WORTH
- EXCESSIVE MOODINESS OR REBELLION
- DEPRESSION
- VIOLENCE
- SCHOOL GRADES/TRUANCY/DROPOUT
- SMOKING CIGARETTES/CHEWING TOBACCO
- DRUG USE
- ALCOHOL USE
- DATING/PARTIES
- SEXUAL BEHAVIORS
- HIV/AIDS
- BIRTH CONTROL
- SEXUAL IDENTITY (HETEROSEXUAL/HOMOSEXUAL)
- WORK OR JOB
- LYING, STEALING OR VANDALISM
- OTHER: ______________________

CONSENT TO TREAT

The above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illness, prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child.

By signing below, I authorize my child to be seen at the school-based clinic and consent to all services listed on page one except what I have listed below.

I DO NOT WANT MY CHILD TO RECEIVE THE FOLLOWING SERVICES:

I, the parent/guardian of said student, give consent for my child to receive services at the school-based clinic. I understand that this consent form will be good until my child leaves this school or until I provide the health center staff with written directions otherwise.

PARENT/GUARDIAN SIGNATURE | DATE | RELATIONSHIP TO CHILD

PRIVACY PRACTICES

All healthcare information is confidential. By signing below you are giving the school-based clinic, school's nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

I authorize AccessHealth to access medication history and share my child's immunization record with West Virginia State Wide Immunization Information System. I agree to Health Data Sharing.

The center may release information regarding treatment to third party payors for billing purposes.

The center may photograph your child to be used for their Electronic Medical Record only.

I am acknowledge that I have received a copy of the Notice of Privacy Practices.

PARENT/GUARDIAN SIGNATURE | DATE

PARENT CONSENT FORM
INFORMED CONSENT FOR
SCHOOL-BASED HEALTH SERVICES

CHILD'S INSURANCE INFORMATION

CHILD'S LEGAL NAME: ______ DATE: ______ PHONE NUMBER: ______

BIRTH DATE: ______ SSN: ______ ADDRESS: ______

COVERED BY AN INSURANCE PLAN?
IF YES, PLEASE FILL IN THE APPROPRIATE SECTION BELOW, AND INCLUDE A COPY OF YOUR INSURANCE CARD.
YES NO

PRIVATE INSURANCE INFORMATION

INSURED PARENT/LEGAL GUARDIAN: ______ BIRTH DATE: ______ SSN: ______

ADDRESS (IF DIFFERENT FROM CHILD): ______ PLACE OF EMPLOYMENT: ______

INSURANCE COMPANY AND COMPLETE ADDRESS: ______

INSURANCE COMPANY PHONE NUMBER: ______ GROUP NUMBER: ______ ID NUMBER: ______ FROM (MONTH/YEAR): ______ TO (MONTH/YEAR): ______

MEDICAID INFORMATION

PLEASE SELECT YOUR CHILD'S MEDICAID CARRIER UNISYS UNICARE CARELINK

MEDICAID ID#: ______ MEMBER ID# (CARELINK) ______ PCP/HMO PROVIDER: ______ PROVIDER PHONE: ______

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

NAME LISTED ON CARD: ______ BIRTH DATE: ______ ID OR PIN# ON CARD: ______ GROUP#: ______

FROM (MONTH/YEAR): ______ TO (MONTH/YEAR): ______ NUMBER OF PEOPLE IN HOUSEHOLD: ______ GROSS MONTHLY INCOME: ______