Consent for School Health Services

Student Information

Last Name: _____ First Name: _____ MI: _____

Homeroom: _____ Grade: _____ Male/Female: _____ Last School Attended: _____

Social Security Number: _____

Race: White Black American Indian Asian Native Hawaiian Hispanic **(circle the one that applies)**

Date of Birth: _____ Address: _____ City: _____ Zip: _____

Mother: _____ Home# _____Work# _____ Cell# _____

Father: _____ Home# _____Work# _____ Cell# _____

Guardian: _____ Home# _____ Work# _____ Cell# _____
(**guardian papers must be on file in the office**)

Emergency Information

Emergency Contact: _____ Home# _____ Work# _____ Cell# _____

Emergency Contact: _____ Home# _____ Work# _____ Cell# _____

Child's Doctor: _____ Phone# _____ Preferred Hospital: _____

Student Medical Information

Circle **ALL** that applies: Diabetes Seizures Asthma ADD ADHD Tobacco use

List **ANY** other significant medical history:_____

Does your child take any routine medications: What? _____ Why? _____

Does your child have **ANY** allergies? (food, medicine, stings) _____

Does the allergy require an Epi-pen? Yes/No _____

The following medications will be provided by the school (Cough Drops, Hydrocortisone, Motrin, Neosporin, Orajel, Saline, Tinactin, Tums, Tylenol, & Vaseline). Contact the School Nurse if you have any objections.

Student Medical Insurance

Does your child have any medical insurance/medicaid? Yes/No _____ Insurance Name: _____

Consent for Health Services/Assignment of Benefits

I consent to care which may include screening, assessments, lab test, treatment, first-aid, over-the-counter and /or prescription medicine, and any other health service given to my child by staff or agents of this Health Department. I authorize the school health clinic staff to release medical information about my child that impacts learning environment to his/her physician/primary care provider, school principal/guidance counselor or designee. I also understand that the information obtained for the school physical including immunization information will be released to my child's school. If my child has Medicaid/K-chip, I authorize payment be made to Purchase District Health Department on my behalf, for services received. I also release this information to Medicaid/K-chip for billing purposes. I understand that no guarantees are being made as to the effects of any exam or treatment on my child. I further understand that I will not be billed for any services that my child receives at the school clinic, except for vaccines that are not required (i.e. flu vaccine, a separate consent will be sent home). I acknowledge receipt of the Notice of Privacy Practices (NPP) for the Purchase District Health Department.

Signature of Parent/Guardian:_____ Date signed:_____

Must be signed for your child to receive first-aid. **(Expires one year after date signed)**