SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM 2016-2017

Columbus City Schools (CCS) partner with many community agencies such as: Columbus Public Health (CPH), Nationwide Children's Hospital (NCH) and OhioHealth to offer School-Based Supplemental Health Services. Our goal is to help improve the health and well-being of students so that they can be successful in school. This one form replaces many of the different permission forms required to provide these services for your child. The health services offered provide quality healthcare in a friendly and familiar school setting at a time that works well for the student and family. We are NOT trying to replace your regular source of healthcare. **School nursing and emergency services will still be provided as always whether or not you choose to take part in these added services.** Some Supplemental Services may not be available at all CCS school buildings (check with your school nurse for questions about service availability). **The information on this consent form will be shared confidentially with the Health Providers listed to the right.** →

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

OhioHealth

Student Information (Print all information in ink)

Patient/Student Name (First, Middle, Last) _____

Parent/Guardian Name (if Patient/Student is less than 18 years) _____

Street Address _____

City _____ **State** OH **Zip Code** _____

Area Code (_____) **Phone Number** _____ **Student Date of Birth (Month-Day-Year)** _____ **Grade** _____ **School Name** _____

Sex: ☐Male ☐Female ☐Other: _____ **Ethnicity:** Hispanic/Latino *(check one)* ☐ Yes ☐ No

Race: Please check **all that apply** for your child**:**
☐ American Indian/Alaskan Native ☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black or African American ☐ Asian ☐ Other: _____

Student's Main Language: ☐ English ☐ Spanish ☐ Somali ☐ Nepali ☐ Other: _____

Consent for Health Services/Treatment

I consent to let the providers participating in the School-Based Supplemental Health Services perform **the following** services/treatment for my child: *(check each service that you want to have available for your child)*

☐ Care and treatment for injury/illness
☐ Physical Examinations (well-child or sports)
☐ Influenza (flu) immunization
☐ Meningococcal (MCV4) immunization (required for 7th and 12th grades)
☐ Tdap immunization (required for 7th grade)
☐ Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule)
☐ Dental screening and sealants (also includes a sealant check next school year and re-application if needed)
☐ Substance abuse prevention counseling
☐ Mental/behavioral health counseling
☐ Pregnancy testing
☐ Birth control
☐ Sexually Transmitted Infection (STI/STD) testing and treatment

By signing this **Consent for Health Services/Treatment**, I agree to the terms and conditions regarding the **Authorization to Release Information** and **Assignment of Insurance Benefits** as explained in this consent form on page 2. I also acknowledge that I have received the information about how to receive **Notice of Privacy Practices** as explained in this consent. I have received and understand the available services as described in the ***School-Based Supplemental Health Services Information for Parents & Students*** handout, which is attached separately.

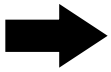
X_____ Parent/Guardian *Printed Name* **X**_____ Parent/Legal Guardian *Signature* **X**_____ Date **X**_____ Phone

Relationship to Student: ☐Mother ☐Father ☐Legal Guardian

-OR-

X_____ Student (Patient) *Printed Name* **X**_____ Student (Patient) *Signature* (if 18 years or older) **X**_____ Date **X**_____ Phone

**Any reference to 'my child' means 'myself' once a minor turns 18 years old*



Student First Name _____ Last Name _____

Consent for Services, continued:

I understand that I will be notified of any services my child receives as well as any abnormal findings and/or further treatment recommendations. I understand that I should contact the school nurse if I have questions about any necessary follow-up care or instructions. For services provided by NCH, I understand that I should call the phone number listed on the After Visit Summary which will be sent home with my child. I understand that this consent will remain valid throughout the 2016-2017, 12 month academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting the School-Based Supplemental Health Services, in writing, remove my child from services.** I have received the handout, *School-Based Supplemental Health Services Information for Parents and Students,* which includes the agencies providing these services, and I understand the services available. It is my responsibility to notify the school nurse with all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage.

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for CPH, NCH and OhioHealth at any CCS school building. I know that I can also view them online at http://columbus.gov/schoolbasedhealthservices/ Copies of the consent form are available at my child's school and blank forms are also available online at http://columbus.gov/schoolbasedhealthservices/

Authorization to Release Information: I hereby authorize CPH, NCH and/or OhioHealth to exchange information with the CCS school nurse(s), school counselor and/or school social worker for the exclusive purpose of treatment or care coordination. Administered immunizations will be entered into the statewide immunization information system (*Ohio ImpactSIIS*). Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987). The School-Based Supplemental Health Services may use student health records to evaluate the quality of care provided and the effectiveness of offering these services. My child's records are protected and can only be accessed by authorized users with restricted access. I understand that this authorization will remain valid throughout the 2016-2017, 12 month academic year unless revoked by me. I may revoke this authorization at any time by providing written notice of my intent to revoke to the School-Based Supplemental Health Services.

Insurance Information: Insurance or other healthcare coverage programs are billed whenever possible to help cover the costs of care. Some School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. I give CPH, NCH and OhioHealth the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which a benefit may be available to pay for services provided to my child through the School-Based Supplemental Health Services.

☐ I agree to allow Nationwide Children's Care Connection, CPH and/or OhioHealth access to my child's individual academic, attendance and behavior records for the current and prior school years so that they can provide better services to my child.

☐ I DO NOT agree to allow Nationwide Children's Care Connection, CPH and/or OhioHealth access to my child's individual academic, attendance and behavior records for the current and prior school years so that they can provide better services to my child.

Health History (to be completed by parent/legal guardian):

Allergies:

Does your child have any allergies? *(please check and explain below):* ☐No ☐Yes

Allergic to	**Reaction**	**Recommended Treatment** *(EpiPen, Benadryl, call 911, etc)*
☐**Medication:** _____		
_____		
_____		
☐**Food:** _____		
_____		
_____		
☐**Insect stings/bites:** _____		
☐**Latex**		
☐**Acrylic/plastics**		
☐**Other:** _____		
_____		

Student First Name _____ Last Name _____

Medications (home and school, daily and as needed):

Name of medicine:	Dose (mg):	When taking:	Why taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **My child does not take any medications** (including pills, liquid medicine, inhalers, nose sprays, medicine patches, or over-the-counter medicine)

Medical Problems and Health Concerns *(check all that apply and explain below)*

General: ☐Chicken Pox disease *(age:___)* ☐Dizziness/Fainting/Passing out
☐Other general problems/concerns: _____

Skin: ☐Skin problem: _____

Eyes, Ears, Nose, Throat, Mouth: ☐Eye, ear, nose, throat, mouth problem: _____

Heart: ☐ Heart problem: _____

Blood: ☐Sickle Cell Disease ☐Immune system problem: _____
☐Clotting disorder: _____ ☐Other blood disorder: _____

Endocrine, Hormones: ☐Diabetes: ☐*Type 1* ☐*Type 2* ☐*Pre-Diabetes*
☐Other endocrine problem: _____

Brain, Nervous System: ☐History of Guillain-Barré Syndrome ☐Seizures (Epilepsy), Date of last seizure: _____
☐Other brain or nervous system problem: _____

Psychological, Mood: ☐Psychological or mood problem: _____

Reproductive, Genital: ☐Pregnant ☐Other reproductive or genital problem: _____

Bones, Muscles: ☐Bone or muscle problem: _____

Lungs and Breathing: ☐Asthma ☐Cystic Fibrosis
☐Other lung or breathing problem: _____

Stomach, Digestion, Liver: ☐Liver disease ☐Other GI or stomach problem: _____

Bladder, Urinary, Kidney: ☐Kidney disease ☐Other bladder or urinary problem: _____

Please <u>explain any medical problems</u> checked in the medical problems and health concerns section: _____

_____

_____

_____

Immunizations:

For children less than 9 years old, has the child received 2 or more doses of the seasonal influenza vaccine before July 1, 2016? (if unsure, check "No") ☐Yes ☐No ☐N/A

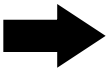
Does the child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as an isolation room of a bone marrow transplant unit)? ☐Yes ☐No

Has the child received a MMR (Measles, Mumps, Rubella), Varicella, Yellow Fever, Oral Polio or Flumist influenza vaccine in the last 30 days? ☐Yes ☐No

In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐Yes ☐No

In the past 3 months, has the child taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? ☐Yes ☐No

History of serious vaccine reaction? ☐Yes ☐No
*If yes, please explain:*_____



Student First Name _____ Last Name _____

Healthcare Providers

Primary Care Provider *(doctor, nurse practitioner, clinic, etc)* _____ **Provider Address** _____ **Provider Phone #** _____

Preferred Pharmacy _____ **Pharmacy Phone #** _____

List any other doctors or specialists your child sees, other than their primary care provider:

Provider Name *(doctor, nurse practitioner, clinic, etc)* _____ Provider Address _____ Provider Phone # _____

Provider Name *(doctor, nurse practitioner, clinic, etc)* _____ Provider Address _____ Provider Phone # _____

Health Insurance

Please check which insurance carrier your child is covered by, or sign below if you don't think your child has insurance. Some School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. You may get a bill for some services if not covered by insurance (see the attached sheet- *School-Based Supplemental Health Services Information for Parents & Students*).

Medicaid Managed Care Plans *(check one below):* Managed Care ID#:_____

☐ buckeye health plan ☐ CareSource Health Care with Heart ☐ MOLINA HEALTHCARE ☐ PARAMOUNT ADVANTAGE ☐ UnitedHealthcare Community Plan

☐ **Ohio Medicaid:** Healthy Start Healthy Families MEDICAID # *(12 digits)*: __ __ __ __ __ __ __ __ __ __ __ __

☐ **The student does not have health insurance** (*sign here for hardship waiver)*
SIGN HERE: I am unable to pay for health services: X_____

☐ **Private Insurance** (other than Medicaid):

Information from insurance card*:* Insurance company: _____

Subscriber ID or member #: _____ Group #: _____

Name of person under whom child is covered: _____ Birth date of insured adult: _____

Phone # on insurance card: _____

Claims address on insurance card: _____

FOR OFFICE USE:

_____CPH AOD _____CPH IZ _____CPH STI _____NCH BH _____OhioHealth
_____CPH Sealants _____CPH flu, Tdap, MCV4 _____CPH PREG _____NCH Primary Care

FOR SCHOOL USE: Room #: _____