FOR SCHOOL USE: Room #: _____

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM 2017-2018

Columbus City Schools (CCS) partners with many community agencies to offer School-Based Supplemental Health Services. This one form replaces many of the different permission forms required to provide these services for your child. **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).

¿Necesita este formulario en Español? *Por favor consulte con la enferma de la escuela o a la oficina.*

Student Information (Print all information in ink.)

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

_____ _____ OH _____
Street Address **City** **State** **Zip Code**

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

Sex: ☐Male ☐Female ☐Prefer to self-describe: _____ **Ethnicity:** Hispanic/Latino *(check one)* ☐Yes ☐No

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

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

Consent for Health Services/Treatment

I consent to let providers participating in 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 immunization (required for 7th & 12th grades)
- ☐ Tdap immunization (required for 7th grade)
- ☐ Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule)
  - ☐DTaP/Td ☐Polio ☐Hepatitis B ☐MMR ☐Varicella
  - ☐Hepatitis A ☐HPV ☐Pneumococcal conjugate ☐Hib
- ☐ Substance abuse prevention education [You're Extra Special (Y.E.S.), Saving Our Selves (S.O.S.), or Leadership Resiliency (L.R.P.)]
- ☐ Dental screening and sealants for 2nd/6th grades (also includes a sealant check next school year and re-application if needed)
- ☐ Eye exam, including dilation (drops are used to make the pupil bigger), vision therapy, the fitting and dispensing of eyeglasses and corneal foreign removal (removing something from the clear, protective outer layer of the eye)
- ☐ Mental/behavioral health counseling
- ☐ Pregnancy testing
- ☐ Birth control
- ☐ Sexually Transmitted Infection (STI/STD) testing, education and/or 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 information about how to receive **Notice of Privacy Practices** as explained in this consent. I also have received and understand available services as described in the ***School-Based Supplemental Health Services Information for Parents & Students*** handout which is attached.

Parent/Guardian Relationship to Student *(if student/patient is less than 18 years old)***:** ☐Mother ☐Father ☐Legal Guardian

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

-OR- *(if student/patient is 18 years or older)*

X_____	**X**_____	**X**_____	**X** _____
Student/Patient *Printed Name*	**Student/Patient** *Signature*	Date	Student Phone

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

Please turn page to complete form.

Student First Name _____ Last Name _____

Consent for Health Services/Treatment, *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 also understand 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 I should call the phone number listed on the After Visit Summary which will be sent home with my child. I understand this consent will remain valid throughout the 2017-2018, 12 month academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that School-Based Supplemental Health Services 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 services, and I understand the services available. It is my responsibility to notify the school nurse of 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, OhioHealth and PrimaryOne Health at any CCS school building. I know I also can 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 at http://columbus.gov/schoolbasedhealthservices/.

Authorization to Release Information: I hereby authorize CPH, NCH, OhioHealth and/or PrimaryOne Health 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). 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 this authorization will remain valid throughout the 2017-2018, 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 School-Based Supplemental Health Services.

Insurance Information: Insurance or other health care coverage programs are billed whenever possible to help cover the cost 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, OhioHealth and PrimaryOne Health 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 School-Based Supplemental Health Services.

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

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

Health Care Providers

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

Date of child's last physical or well child exam: _____

-OR-

☐**My child has <u>not</u> had a physical or well child exam in the last 12 months**

These health services provide quality health care 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 health care.

Please turn page to complete form.

Student First Name _____ Last Name _____

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

Allergies:

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

Allergic to	**Reaction**
☐Medication: _____	_____
☐Food: _____	_____
☐Latex	_____
☐Acrylic/plastics	_____
☐Other: _____	_____

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

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

***Attach a separate list if needed**

☐**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 "Yes" or "No" for each item and explain below if necessary.)*

Chicken Pox disease *(age:___)*	☐Yes	☐No
Dizziness/fainting/passing out	☐Yes	☐No
Psychological or mood problem *(please explain)*	☐Yes	☐No
Development problems	☐Yes	☐No
Surgery or admitted to the hospital in the last year	☐Yes	☐No
Heart problem	☐Yes	☐No
Sickle cell disease	☐Yes	☐No
Immune system problem *(please explain)*	☐Yes	☐No
Clotting disorder *(please explain)*	☐Yes	☐No
Other blood disorder *(please explain)*	☐Yes	☐No
Type 1 Diabetes	☐Yes	☐No
Type 2 Diabetes	☐Yes	☐No
Pre-Diabetes	☐Yes	☐No
Other endocrine disorder *(please explain)*	☐Yes	☐No

History of Guillain-Barré Syndrome	☐Yes	☐No
Seizures (Epilepsy) *Date of last seizure:*	☐Yes	☐No
Other brain or nervous system problem *(please explain)*	☐Yes	☐No
Asthma	☐Yes	☐No
Cystic Fibrosis	☐Yes	☐No
Other lung or breathing problem *(please explain)*	☐Yes	☐No
Liver disease	☐Yes	☐No
Other GI or stomach problem *(please explain)*	☐Yes	☐No
Kidney disease	☐Yes	☐No
Other bladder or urinary problem *(please explain)*	☐Yes	☐No
Pregnant *(girls only)*	☐Yes	☐No
Other problems/concerns *(please explain)*	☐Yes	☐No

Please explain any medical problems you checked in this section: _____

_____

_____

_____

_____

Please turn page to complete form.

Student First Name _____ Last Name _____

Health History, *continued* (to be completed by parent/legal guardian)

Immunization History:

For children less than 9, has the child ever received 2 or more doses of the flu vaccine before July 1, 2017? (If unsure, check "No".)	☐Yes ☐No ☐NA
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? *If yes, which vaccine and explain:*	☐Yes ☐No

Health Insurance

Please check which insurance carrier covers your child 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 *School-Based Supplemental Health Services Information for Parents & Students* sheet.)

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

*Medicaid UHC not offered by your job

☐ **Ohio Medicaid:** Healthy Start Healthy Families 1-800-324-8680 OHIO 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: _____