Consent for Medical Care/Treatment



## NATIONWIDE CHILDREN'S HOSPITAL SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES Consent Form

KIPP Academy Columbus and Nationwide Children's Hospital (NCH) are partnering together to offer School-Based Supplemental Health Services to any KIPP student. The goal of this program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the school health services offered is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to 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 you consent to participate in the program or not.

	<u> </u>					
Patient/Stud	dent Name	Parent/Guardian	Parent/Guardian if Patient/Student is less than 18 years			
Street Addre	ess	City	State	Zip Code		
( )		<u> </u>				
Area Code	Phone Number	Student Date of Birth (Mon	th-Day-Year) Gr	rade		
Choose <u>one</u>	of the following:					
services/trea	to allow the health care providers of Nationwic trent (including medications and tests, see lis atient/student.	le Children's Hospital ("NCH") of the below) that may be needed to	who are providing service diagnose, treat, and/or o	es at KIPP Columbus to pocare for the needs of the a	erform <u>all</u> above-	
-OR-						
	t to allow the NCH health care providers who a ferenced patient/student:	re providing services at KIPP (	Columbus to perform <b>onl</b> y	the following services/t	reatment for th	
	Care and treatment for any injury/illness		coccal - following the Am	ol attendance (DTaP,Tda erican Academy of	p, Polio, MMR,	
	Physical Examinations	☐ Substance abu	se prevention counseling			
	All immunizations recommended but not requ the Ohio Department of Health	ired	oral health counseling			
	HPV immunization	☐ Pregnancy test	ing			
	Influenza (flu) immunization	☐ Birth Control				
	Pneumococcal immunization	☐ Prenatal (pregr screen and other p		stpartum (after pregnancy	) care, genetic	
	Hepatitis A immunization	☐ Sexually Trans	mitted Infection (STI/STD	) testing and treatment		

I understand that this consent will remain valid throughout the student's enrollment at KIPP Columbus unless revoked. You may revoke this consent for treatment at any time by making a written request to KIPP Columbus to have me/my child removed from services. I have received the handout, *School-Based Supplemental Health Services Information for Parents and Students*, and I understand the services available. It is my responsibility to tell the School-Based Supplemental Health Services about changes in insurance coverage, and to notify the school office manager with all updates or changes to my child's health condition(s), immunization records, or medications.

## **Health History**

iding pills, liquid medicine, inhalers, licine, food, or insect stings or bites? Reaction:	_	dicine patches, or over-t  ☐Yes (please check a	he-counter medicine).
icine, food, or insect stings or bites?	_	_	he-counter medicine).
	□No	☐Yes (please check a	
Reaction:		"	and explain):
		Treatment:	
eck all that apply) gnant erweight tting in pants Day Night (stool) in pants neussion sebleeds zures (Epilepsy) bliosis kle Cell Disease kle Cell Trait eping problems eech problems cken Pox Disease e:)	□Glasses [ □Hearing Proble Has hearing Right/Left e □ Alcohol/drug a □Tobacco use □Cigarette: □Smokeles (chew, sn □Tuberculosis (' □Active TB a □Latent TB a □Comple	☐Contacts em g aid for ear (circle) abuse s ☐Cigars es tobacco suff) TB) age eted treatment	Sensory Processing Disorder  ADD/ADHD (circle one) Other Learning Disability Anxiety Bipolar Disorder Depression OCD History of hurting self History of suicide attempt(s) Other:
-	eck all that apply) egnant erweight etting in pants Day Night I (stool) in pants ncussion sebleeds izures (Epilepsy) bliosis ekle Cell Disease ekle Cell Trait eping problems eech problems icken Pox Disease ee:)	eck all that apply) egnant	eck all that apply)  egnant

## KIPP Columbus

Notice of Privacy Practices Acknowledgement

I have been notified that NCH's Notice of Privacy Practices is available to me at any KIPP

Columbus school building upon my request. I can also view them online at

http://anchor.columbuschildrens.net/webapplications2/DocContent/Documents/Policies/XI25A\_Notice\_of\_Privacy\_Practices\_ENGLISH.pdf.

Authorization to Release Information I hereby authorize NCH and KIPP Columbus to share/release/exchange information about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school for treatment purposes, care coordination and/or educational purposes. NCH may also request access to my child's academic, attendance and behavior records for the current, prior and future school years so that they can provide better services to my child and understand the impact of their program. I understand this information will be kept confidential. I also hereby authorize NCH to share/release/exchange all such information with my doctors, my referring doctors, or referring/referral health care providers; and/or to any insurance company or organization that helps pay my bill. NCH may also give information to any welfare organization, to which I have applied or may apply for aid. Administered immunizations will be entered into the statewide immunization information system, Ohio ImpactSIIS. NCH I understand that KIPP Columbus is covered under the federal regulations that govern the privacy of educational records and that any personal health information disclosed under this authorization may be protected by those regulations. Re-disclosure 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). My/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 my child's enrollment at KIPP Columbus, unless I revoke this authorization. I may revoke this authorization at any time by providing written notice of my intent to revoke to KIPP Columbus and/or NCH. I understand that I am not required to sign this authorization form and that NCH will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization. The health information used and/or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. Neither NCH nor KIPP Columbus is responsible for the use of information, in whole or in part, by third parties. This authorization is given without promise of compensation. I have received a copy of this form and I understand that I have the right to inspect or copy any health information disclosed (reasonable copying fees may apply to any copying services). This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity.

Assignment of Insurance Benefits

I assign to NCH, all rights and claims for reimbursement under any private health insurance policy, Medicare,

Medicaid, or any other programs that I identify for which benefits may be available to pay for services provided to me through the School-Based

Supplemental Health Services.

X	X	X	X
Parent/Guardian Printed Name	Parent/Legal Guardian Signature (if student is less than 18 years)	Date/Time	Phone
Relationship to Student			
Student (Patient) Printed Name	Student (Patient) Signature (if 18 years or older)	Date/Time	Phone