

NATIONWIDE CHILDREN'S HOSPITAL SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Office Use Only
Patient ID:

Nationwide Children's Hospital ("NCH") partners with schools to offer health services (including Behavioral Health and Dental) to students. The goal of this program is to help improve the health and well-being of students so 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 (where available) and emergency services will still be provided as always whether you consent to participate in the program or not.**

Student / Family Information (Print all information in ink.)					
Student's First & Last Name:		Date of Birth (month/day/year):		Gender:	Race/Ethnicity:
Parent/Guardian #1 First & Last Name:		Parent Email:		Relationship to Student:	Phone Number:
Parent/Guardian #2 First & Last Name:		Parent Email:		Relationship to Student:	Phone Number:
Preferred Language:	Street Address:		City:	State:	Zip Code:

Health Provider Information	Insurance Information
<p>Date of student's last physical _____</p> <p><input type="checkbox"/> No physical in last 12 months</p> <p>Doctor's Name/Address/Phone _____</p> <p>Dentist's Name/Address/Phone _____</p> <p><input type="checkbox"/> No cleaning or dental exam in last 12 months</p> <p>Pharmacy Name/Location _____</p>	<p><input type="checkbox"/> Medicaid <input type="checkbox"/> Caresource <input type="checkbox"/> Molina <input type="checkbox"/> Other <input type="checkbox"/> Private Insurance Plan</p> <p><input type="checkbox"/> NONE, please connect me to NCH financial counselor</p> <p>Policyholder's Name _____ Policyholder's Date of Birth _____</p> <p>Insurance Name _____ Insurance address _____</p> <p>Group & ID # _____</p> <p>Dental Insurance (If different than medical):</p> <p>Insurance Name _____ Insurance address _____</p> <p>Group & ID # _____</p> <p><i>All services provided are billed to insurance. If you do not have insurance, NCH will connect you to financial assistance. No child is denied services for inability to pay.</i></p>

I consent to allow the NCH health care providers who are providing services to perform the following services / treatment and vaccines for the above referenced student:

Consent for Medical Care / Treatment	
Below, place an X next to each service.	
<input type="checkbox"/>	Care and treatment for any injury/illness, and any necessary advanced imaging and bracing, splinting and casting
<input type="checkbox"/>	Physical examinations / well-child (i.e. sports, work, school) Note: Well-child care includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate.
<input type="checkbox"/>	Dental exams and procedures including: teeth cleaning, fluoride treatment, dental x-rays, sealants, fillings, stainless steel crowns, pulpotomies, extractions, and silver diamine fluoride (SDF) treatment
<input type="checkbox"/>	Behavioral Health early prevention and wellness groups. Skill Building – social emotional learning and development of coping skills. (Your insurance won't be billed for prevention and wellness groups)
Consent for Vaccinations	
I wish to have <u>ALL</u> vaccines available for my student.	
<input type="checkbox"/> YES , I want my child to receive all available vaccines.	
<input type="checkbox"/> NO , I only want my child to receive the vaccines below (check all that apply)	
<input type="checkbox"/>	DTaP / Tdap / Td
<input type="checkbox"/>	Meningococcal / Men B
<input type="checkbox"/>	MMR
<input type="checkbox"/>	Varicella
<input type="checkbox"/>	Polio
<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	Influenza (flu)
<input type="checkbox"/>	HPV
<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	Pneumococcal
<input type="checkbox"/>	Hib

X _____ Parent/Guardian <i>Printed Name</i> (if student less than 18)	X _____ Parent/Guardian <i>Signature</i> Date/Time
X _____ (if student 18+) Student <i>Printed Name</i>	X _____ Student <i>Signature</i> Date/Time

Student Health and Dental History			
Select and describe if your student has or has had any of the following:			
Medications <input type="checkbox"/> YES (list below) <input type="checkbox"/> NO	Allergies <input type="checkbox"/> YES (explain below) <input type="checkbox"/> NO	Surgeries (when?) <input type="checkbox"/> YES (explain below) <input type="checkbox"/> NO	Other medical problems or health concerns <input type="checkbox"/> YES (explain below) <input type="checkbox"/> NO
1)	1)	1)	1)
2)	2)	2)	2)
3)	3)	3)	3)
Please explain any other medical information:			

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that NCH's Notice of Privacy Practices is available upon my request at any school building where services are provided. I can also view the Notice of Privacy Practices online at <https://www.nationwidechildrens.org/your-visit/medical-records/privacy-notice>.

Assignment of Insurance Benefits: Insurance or other health coverage programs are billed whenever possible to help cover the cost of care. 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. To find out if you are eligible for financial assistance, contact Financial Services at (614) 722-2070 or visit [NationwideChildrens.org/Financial-Assistance](https://www.nationwidechildrens.org/financial-assistance).

Authorization to Release Medical Information: I hereby authorize NCH and my child's school to share/release/exchange information with school nurses, school counselors, school social workers and/or school administrators 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. 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 ImpactSIS*. I understand that my child's school 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 his or her school for the current 12 month academic year commencing August 1, unless I revoke this authorization. I may revoke this authorization at any time by providing written notice of my intent to revoke to my child's school 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 my child's school 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.