SCHOOL-BASED ASTHMA THERAPY PROGRAM CONSENT FORM

My Child, _____ (MRN: _____), has my permission to participate in the Nationwide Children's Hospital (NCH) School-Based Asthma Therapy (SBAT) Program, which NCH provides in collaboration with Partners for Kids (PFK). This permission form will be valid for the entire school year. I understand that I will need to re-enroll my child each year if I wish for his/her participation in the program to continue.

I understand that my child's school nurse or doctor has identified him/her as someone who would benefit from this program because of his/her asthma symptoms. An NCH nurse will contact me to do an initial assessment of my child over the phone. I agree to be honest about my child's asthma symptoms, and to let the nurse know of any changes in symptoms when she calls to check in.

I give permission for NCH to receive and review copies of my child's_____ School District Health Records. I also give permission for NCH health care providers to talk to my child's primary care doctor to coordinate care. I understand that they will discuss and review my child's current medications, and will agree to a care plan regarding my child's asthma controller therapy medication.

I give permission to allow the NCH outpatient pharmacy to deliver asthma controller medication to my child's school, and to bill my insurance company for any costs of these medications. I agree to allow the school nurse to give the asthma controller medication to my child during school, and to report incidents to NCH when my child requires rescue therapy during school and/or early dismissal due to his/her asthma symptoms. I understand that a written report will be sent to my child's doctor when necessary.

Name, phone and address of child's primary care doctor (pediatrician), asthma care physician or clinic (if he/she has one):
Primary Care Doctor: _____
Asthma Physician/Clinic:
_____

I understand that I have the right to take part in decisions about my child's health care and treatment plan. I have received a copy of the Patient Rights and Responsibilities, and my questions have been answered.

I understand that NCH is a teaching hospital and that my child may be included in teaching, research, and training programs. I also understand that I may be contacted for participation and/or follow-up regarding these programs.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me about the result of my child's examination.

I agree to let NCH share and exchange medical information and other records concerning my child, including clinical research, physical, mental, drug alcohol, HIV or AIDS (and information that state and federal law and accreditation agencies require), with the school, my child's doctors, 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. If medical information is shared with school officials other than the school nurse, I understand that such information will only be shared if it is relevant to my child's education. NCH's SBAT program 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 this program. I understand that this information will be kept confidential.

I assign to NCH, my child's doctor and other health care professionals involved in my child's care, all of my rights and claims for reimbursement under my commercial health insurance policy (if any), Medicare, Medicaid, or any other programs that I identify which may be available to pay NCH for the medical care provided by NCH to my child. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I have a right to see a list of prices for common medical and surgical procedures. I can ask the Patient Accounts department (phone number below) about this price list or about my bill.

I understand that I am able to revoke this consent at any time by notifying NCH in writing at the following address: _____.

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices of Integrated Child Healthcare Arrangement (ICHA), which outlines my rights and describes the ways that my child's protected health information may be used or disclosed by NCH.

Medical services provided are billable services and may be billed directly to your insurance company. If you do not have insurance for your child, please contact Patient Accounts at 614-722-2055 for assistance. For questions about your child's medications, treatment plan or enrollment in this program, please contact SBAT@nationwidechildrens.org.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE MEDICAL TREATMENT OF MY CHILD.

Printed name:_____ Relationship:_____
Parent/guardian

Signature: _____ Date:_____ Time_____
Parent/guardian

Witness:_____ Date:_____ Time_____
(example: neighbor, adult relative)