School Based Health Consent for Services
The Wellness Center @ Atkinson

Please read carefully: In order for us to see your child in ***The Wellness Center@ Atkinson***, all pages of this form must be completed by the child's parent or legal guardian**, <u>signed and dated</u>** in ink in the appropriate places. Students should return the completed form to their teacher. Consent is for the 2016-17 school year and may be withdrawn at any time.

Child's School:_____

_____ _____ _____
Student's Last Name First Name/ Middle Initial Date of Birth

Social Security Number: _____ Gender: ___Male ___Female

Race: ___American Indian or Alaska Native ___Asian ___Black or African American
___ Native Hawaiian or Other Pacific Islander ___White

Ethnicity: Are you Hispanic or Latino? ___Yes ___No
Primary Language: _____ Religion Preference: (optional) _____

Address: _____
City _____ State _____ Zip Code _____

Physical Address (If Mailing Address is a P.O. Box):
_____

Home / Cell Phone Number: _____

<u>In Case of Emergency Please Contact:</u>
Name of Mother/ Legal Guardian_____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

Name of Father/ Legal Guardian: _____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

If Immediate Family is Not Available, Please Contact:

Name and Relationship to Child: _____

_____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number

Student's Medical History

The following information will aid ***The Wellness Center@ Atkinson*** in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

___ Measles
___ Mumps
___ Anemia
___ Birth Defects
___ Diabetes
___ Chicken Pox
___ Rheumatic Fever
___ Asthma
___ Scarlet Fever
___ Seizures
___ Unexplained Weight Loss
___ Unexplained Tiredness
___ Persistent Cough
___ Unexplained Weight Gain
___ Leukemia
___ Sleep Problems
___ Joint or Muscle Pain or Stiffness
___ Exposed to Tuberculosis
___ Shortness of Breath
___ Head, Eyes, Ears, Throat Problems
___ Blood Transfusions
___ Anaphylactic Episodes
___ Chest Pain
___ Stomach or Bowel Problems

If you answered yes to any of the above, please explain: _____
_____

Student's Medications (with dosage) taken on a regular basis: _____

****You will be asked to complete a separate JCPS Medication Consent form if you desire the JCPS School Nurse to administer this medication in the School.**

Student's doctor: _____ Address: _____
Student's dentist: _____ Address: _____
Student's Pharmacy: _____ Address: _____

___ Surgical History (reason/date):_____
___ Hospitalizations (reason / date): _____
___ Serious injuries or illnesses (describe): _____

When was the last time your child was seen by a doctor?

_____
Doctor's Name Reason Date

Does the student have any allergies to FOOD, MEDICATIONS, OR ENVIRONMENTAL POLLENS
___ Yes ___No
IF YES, PLEASE LIST: _____
Have there been any recent upsets in the family that might affect your child? ___Yes ___No
If you answered yes please explain: _____

Family Medical History:

Please check the appropriate space if any of the child's blood relatives (mother, father, brother, sister, grandmother, grandfather) has any of the following conditions.

_____HIV/AIDS
_____Alcohol/Drug Addiction
___ __Alzhemier's
___ __Arthritis
_____ Asthma
_____ Birth Defects
_____ Bleeding Disorders
_____ Cancer
_____ COPD/Emphysema/Bronchitis
_____ Diabetes
_____Epilepsy/Seizures
_____ Heart Attack/Stroke
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease
_____ Liver Disease/Hepatitis
_____Mental Illness
_____Osteoporosis
_____Sickle Cell
_____ Thyroid Disorder
_____Tuberculosis/TB
_____Other:

Immunization Status:
Is your child up to date on immunizations? ___Yes ___No
Where is the child's immunization record on file: _____
___Yes, I give permission for school nurse to request a copy of immunization record

Other:
Do you have concerns about your child's health? ___Yes ___No

Is your child exposed to second hand smoke? ___Yes ___No

Does your child smoke and/or use tobacco products? ___Yes ___No

Does your child drink alcohol? ___Yes ___No

Cross out any Over the Counter medications below you DO NOT want your child to receive

___ Acetaminophen (Generic name for Tylenol)
____ Topical mouth/tool pain reliever (Orajel, Orasol etc.)
____ Lotion
____Cough Drops
____ Diphenhydramine (Generic for Benadryl)
___ Saline for wound cleaning
____ Tums for indigestion
____ Ibuprofen (Generic name for Advil)
____ Lip Ointment (Blistex, Chapstick etc.)
____ Sore throat spray
____ Finger stick blood glucose testing
____ Triple antibiotic ointment (Neosporin, Bacitracin etc.)
____ Topical Antiseptic (Benzalkonium Chloride)
____ Hydrocortisone 1% Cream
____ Eye Wash, Irrigating Solution
____ Immodium for diarrhea

INCOME ***Note: Shawnee Christian Healthcare Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Family Size	**Annual Income (please circle one on the row of your family size)**			
1	**Below $11,770**	**$11,771-17,655**	**$17,656-23,540**	**Above $23,540**
2	**Below $15,930**	**$15,931-23,895**	**$23,896-31,860**	**Above $31,860**
3	**Below $20.090**	**$20,091-30,135**	**$30,136-40,180**	**Above $40,180**
4	**Below $24,250**	**$24,251-36,375**	**$36,376-48,500**	**Above $48,500**
5	**Below $28,410**	**$28,411-42,615**	**$42,616-56,820**	**Above $56,820**
6	**Below $32,570**	**$32,571-48,855**	**$48,856-65-140**	**Above $65,140**

Please complete the following insurance information for your student. This information is **required** for the students health record to be complete but will ONLY be billed if services are provided the by Nurse Practitioner of ***The Wellness Center@ Atkinson*** . JCPS School nurse visits are not billed to insurance.

Medical Card/Managed Care Organization (MCOs)
Insurance Company: _____ Policy Number: _____
Health Insurance- Please Fully Complete and Please attach copy of insurance card
Insurance Company: _____ Policy Number: _____
Group Number: _____
Send Medical Claims to Address on Card: _____
Name on Insurance Card: _____
Policy Holder Information:
Name of Primary Insured (policy holder): _____
Relationship to Patient: _____
Social Security Number of Primary Insured (policy holder): _____
Gender: _____ Policy Holder's Date of Birth:_____
Mailing Address: _____

Shawnee Christian Healthcare Center, Inc.
Assignment of Benefits / Consent for Treatment

I consent to the customary examinations, tests and procedures that may be deemed necessary for treatment of my child's condition by Nurses (RN) and / or Family Nurse Practitioners of the Medical Staff and Employees of Shawnee Christian Healthcare Center. Consent is hereby given for such visits to ***The Wellness Center@ Atkinson***, and such examinations, treatment, tests and procedures by such employees of ***The Wellness Center@ Atkinson.***

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment.

I authorize payment of medical benefits to the supplier for services provided by Shawnee Christian Healthcare Center.

I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. *Visits to the school nurse are not billed.

Authorize for Release of Medical Information for Billing Purpose Only

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release Shawnee Christian Healthcare Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

_____ _____

Date Signature of the Parent/Legal Guardian

_____ _____

Best **phone number** to reach you **Email** to link you to Patient Portal for child's health record

_____ _____

Date Signature of Witness

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

_____

Date Phone Number Witness Name Address

_____

Date Phone Number Witness Name Address