

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM 2016-2017

Columbus City Schools (CCS) partner with many community agencies such as: Columbus Public Health (CPH), Nationwide Children's Hospital (NCH) and OhioHealth to offer School-Based Supplemental Health Services. Our goal is to help improve the health and well-being of students so that they can be successful in school. This one form replaces many of the different permission forms required to provide these services for your child. The health services offered provide quality healthcare 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 healthcare. **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). **The information on this consent form will be shared confidentially with the Health Providers listed to the right.** →



Student Information (Print all information in ink)

Patient/Student Name (First, Middle, Last) _____ **Parent/Guardian Name (if Patient/Student is less than 18 years)** _____

Street Address _____ **City** _____ **OH State** _____ **Zip Code** _____
 (_____) _____
Area Code _____ **Phone Number** _____ **Student Date of Birth (Month-Day-Year)** _____ **Grade** _____ **School Name** _____
Sex: Male Female Other: _____ **Ethnicity:** Hispanic/Latino (*check one*) Yes No
Race: Please check **all that apply** for your child:
 American Indian/Alaskan Native White Native Hawaiian/Pacific Islander
 Black or African American Asian Other: _____
Student's Main Language: English Spanish Somali Nepali Other: _____

Consent for Health Services/Treatment

I consent to let the providers participating in the 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*)

- | | |
|--|--|
| <input type="checkbox"/> Care and treatment for injury/illness | <input type="checkbox"/> Dental screening and sealants (also includes a sealant check next school year and re-application if needed) |
| <input type="checkbox"/> Physical Examinations (well-child or sports) | <input type="checkbox"/> Substance abuse prevention counseling |
| <input type="checkbox"/> Influenza (flu) immunization | <input type="checkbox"/> Mental/behavioral health counseling |
| <input type="checkbox"/> Meningococcal (MCV4) immunization (required for 7 th and 12 th grades) | <input type="checkbox"/> Pregnancy testing |
| <input type="checkbox"/> Tdap immunization (required for 7 th grade) | <input type="checkbox"/> Birth control |
| <input type="checkbox"/> Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule) | <input type="checkbox"/> Sexually Transmitted Infection (STI/STD) testing and 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 the information about how to receive **Notice of Privacy Practices** as explained in this consent. I have received and understand the available services as described in the **School-Based Supplemental Health Services Information for Parents & Students** handout, which is attached separately.

X _____ **X** _____ **X** _____ **X** _____
 Parent/Guardian *Printed Name* Parent/Legal Guardian *Signature* Date Phone

Relationship to Student: Mother Father Legal Guardian

-OR-

X _____ **X** _____ **X** _____ **X** _____
 Student (Patient) *Printed Name* Student (Patient) *Signature* (if 18 years or older) Date Phone

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



Consent for Services, 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 understand that 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 that I should call the phone number listed on the After Visit Summary which will be sent home with my child. I understand that this consent will remain valid throughout the 2016-2017, 12 month academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting the School-Based Supplemental Health Services, in writing, 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 these services, and I understand the services available. It is my responsibility to notify the school nurse with 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 and OhioHealth at any CCS school building. I know that I can also 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 online at <http://columbus.gov/schoolbasedhealthservices/>

Authorization to Release Information: I hereby authorize CPH, NCH and/or OhioHealth 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). The 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 that this authorization will remain valid throughout the 2016-2017, 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 the School-Based Supplemental Health Services.

Insurance Information: Insurance or other healthcare coverage programs are billed whenever possible to help cover the costs 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 and OhioHealth 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 the School-Based Supplemental Health Services.

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

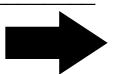
I DO NOT agree to allow Nationwide Children's Care Connection, CPH and/or OhioHealth access to my child's individual academic, attendance and behavior records for the current and prior school years so that they can provide better services to my child.

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

Allergies:

Does your child have any allergies? (please check and explain below): No Yes

Allergic to	Reaction	Recommended Treatment (EpiPen, Benadryl, call 911, etc)
<input type="checkbox"/> Medication: _____		
<input type="checkbox"/> Food: _____		
<input type="checkbox"/> Insect stings/bites: _____		
<input type="checkbox"/> Latex		
<input type="checkbox"/> Acrylic/plastics		
<input type="checkbox"/> Other: _____		



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

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

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 all that apply and explain below)

General: Chicken Pox disease (age:____) Dizziness/Fainting/Passing out
 Other general problems/concerns: _____

Skin: Skin problem: _____

Eyes, Ears, Nose, Throat, Mouth: Eye, ear, nose, throat, mouth problem: _____

Heart: Heart problem: _____

Blood: Sickle Cell Disease Immune system problem: _____
 Clotting disorder: _____ Other blood disorder: _____

Endocrine, Hormones: Diabetes: Type 1 Type 2 Pre-Diabetes
 Other endocrine problem: _____

Brain, Nervous System: History of Guillain-Barré Syndrome Seizures (Epilepsy), Date of last seizure: _____
 Other brain or nervous system problem: _____

Psychological, Mood: Psychological or mood problem: _____

Reproductive, Genital: Pregnant Other reproductive or genital problem: _____

Bones, Muscles: Bone or muscle problem: _____

Lungs and Breathing: Asthma Cystic Fibrosis
 Other lung or breathing problem: _____

Stomach, Digestion, Liver: Liver disease Other GI or stomach problem: _____

Bladder, Urinary, Kidney: Kidney disease Other bladder or urinary problem: _____

Please explain any medical problems checked in the medical problems and health concerns section: _____

Immunizations:

For children less than 9 years old, has the child received 2 or more doses of the seasonal influenza vaccine before July 1, 2016? (if unsure, check "No") Yes No N/A

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? Yes No
If yes, please explain: _____



Healthcare Providers

Primary Care Provider (doctor, nurse practitioner, clinic, etc)

Provider Address

Provider Phone #

Preferred Pharmacy

Pharmacy Phone #

List any other doctors or specialists your child sees, other than their primary care provider:

Provider Name (doctor, nurse practitioner, clinic, etc)

Provider Address

Provider Phone #

Provider Name (doctor, nurse practitioner, clinic, etc)

Provider Address


Provider Phone #

Health Insurance

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

Medicaid Managed Care Plans (check one below): Managed Care ID#: _____



Ohio Medicaid:  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: _____

FOR OFFICE USE:

____ CPH AOD ____ CPH IZ ____ CPH STI ____ NCH BH ____ OhioHealth
____ CPH Sealants ____ CPH flu, Tdap, MCV4 ____ CPH PREG ____ NCH Primary Care

FOR SCHOOL USE: Room #: _____