FOR SCHOOL USE: Room #:

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM 2019-2020

Columbus City Schools (CCS) partners with Columbus Public Health (CPH) to offer School-Based Supplemental Health Services. We are not trying to replace your regular source of health care. **School nursing and emergency services will still be provided as always whether or not you choose to take part in these added services.** Check with your school nurse for questions about service availability.

¿Necesita este formulario en Español? *Por favor consulte con la enferma de la escuela o a la oficina.*

Student Information (Print all information in ink.)

Student/Patient Name (First, Middle, Last) _____ **Student Preferred Name** _____

Street Address _____ **City** _____ **State** OH **Zip Code** _____

Area Code (_____) **Phone Number** _____ **Student Date of Birth (Month-Day-Year)** _____ **Grade** _____ **School Name** _____

Sex: ☐Male ☐Female ☐Prefer to self-describe: _____ **Ethnicity:** Hispanic/Latino *(check one)* ☐Yes ☐No

Race: Please check **all that apply** for your child**:** ☐Black or African American ☐White ☐Asian ☐Native Hawaiian/Pacific Islander ☐American Indian/Alaskan Native ☐Other: _____

Student's Main Language: ☐English ☐Spanish ☐Somali ☐Nepali ☐French ☐Arabic ☐Other: _____

Consent for Health Services/Treatment, Privacy Practices & Authorization to Release Information

I consent to **the following** checked health services for my child: *(Check all that apply.)*

☐ Influenza (flu) immunization
☐ Meningococcal immunization (required for 7th & 12th grades)
☐ Tdap immunization (required for 7th grade)
☐ Other age-appropriate immunizations, following the American Academy of Pediatrics immunization schedule
☐ Dental screening and sealants for 2nd & 6th grades (includes a sealant check next school year and re-application if needed)
☐ Sexual Wellness Services (STI/STD) testing, pregnancy testing and/or birth control (condoms)

By signing this **Consent for Health Services/Treatment**, I acknowledge and assert that I am a parent or legal guardian of the student/patient named above, and I agree to the terms and conditions regarding the **Authorization to Release Information** and **Assignment of Insurance Benefits** as explained in this consent. I also acknowledge that a copy of the **Notice of Privacy Practices** form, and the consent form are available at any CCS school building or online at http://columbus.gov/schoolbasedhealthservices/. Additional information about these services can also be found online.

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 hereby authorize CPH to exchange information with the CCS school nurse(s). My child's records are protected and can only be accessed by authorized users with restricted access. I also understand I should contact the school nurse if I have questions. I understand this consent will remain valid throughout the current, 12 month academic year unless revoked by me in writing. It is my responsibility to notify the school nurse of all updates or changes to my child's health condition(s), immunization records or insurance coverage.

Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. CPH 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 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 School-Based Supplemental Health Services.

X_____ **Parent/Guardian** *Printed Name* | **X**_____ **Parent/Guardian** *Signature* | **X**_____ Date | **X** _____ Parent/Guardian Cell Phone

-OR- *(if student/patient is 18 years or older)*

X_____ **Student/Patient** *Printed Name* | **X**_____ **Student/Patient** *Signature* | **X**_____ Date | **X** _____ Student Phone

FOR OFFICE USE: NextGen #: _____

Please turn page to complete form.

Student First Name _____ Last Name _____

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

Allergies:

☐No ☐Yes **Does your child have any allergies?** *(Please check and explain below.)*

Allergic to:	**Reaction**	**Allergic to:**	**Reaction**
☐Medication: _____	_____	☐Latex	_____
_____	_____	☐Acrylic/plastics	_____
☐Food: _____	_____	☐Other: _____	_____
_____	_____	_____	_____

Medical Problems and Health Concerns *(Check "Yes" or "No" for each item and explain below if necessary.)*

Chicken Pox disease *(age:___)*	☐Yes	☐No	**History of Guillain-Barré Syndrome**	☐Yes	☐No
Dizziness/fainting/passing out	☐Yes	☐No	**Seizures (Epilepsy)**	☐Yes	☐No
Psychological or mood problem	☐Yes	☐No	**Brain or nervous system problem**	☐Yes	☐No
Development problems	☐Yes	☐No	**Asthma**	☐Yes	☐No
Heart problem	☐Yes	☐No	**Cystic Fibrosis**	☐Yes	☐No
Sickle cell disease	☐Yes	☐No	**Other lung or breathing problem**	☐Yes	☐No
Immune system problem	☐Yes	☐No	**Liver disease**	☐Yes	☐No
Clotting disorder or hemophilia	☐Yes	☐No	**Other GI or stomach problem**	☐Yes	☐No
Other blood disorder	☐Yes	☐No	**Kidney disease**	☐Yes	☐No
Diabetes	☐Yes	☐No	**Other problems/concerns**	☐Yes	☐No

Please explain any medical problems you checked in this section:_____
_____

Immunization History:

For children <u>less than 9</u>, has the child ever received 2 or more doses of the flu vaccine before July 1, 2019? (If unsure, check "No".)	☐Yes	☐No	☐NA
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	
Has the child ever had a **serious reaction after getting a vaccine**? *If yes, which vaccine and explain the reaction:*	☐Yes	☐No	

Health Insurance

Please check which insurance carrier covers your child or sign below if you don't think your child has insurance. CPH School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay.

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

☐ buckeye health plan ☐ CareSource (Health Care with Heart)
☐ PARAMOUNT ADVANTAGE ☐ MOLINA HEALTHCARE
☐ UnitedHealthcare Community Plan **Medicaid UHC not offered by your job*
☐ Healthy Start Healthy Families 1-800-234-8680 **Ohio Medicaid#**: _____

☐ **Private Insurance** (other than Medicaid):
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: _____

The student does not have health insurance. ☐ (*Sign below for hardship waiver.)*

SIGN HERE: I am unable to pay for health services. X_____