

## Erie County Health Department/Erie County Community Health Center

## **School Based Health Center Consent Form**

<mark>ame of</mark>	Student		Date of Birth		<mark>Grade</mark>						
					n per student must be signed ann	ually and on file at the healtl					
r the stu	udent to receive th	ese services. By marking	"yes" I consent to the following	<b>g:</b>							
	Yes! I consent for this form to act as valid informed consent for treatment at all sites of the Erie County Community Health Center.										
	Yes! I consent fo	or my child to receive	Medical Care and/or N	1ental Health* care	e through the School Based He	alth Center					
		<del>-</del>	_		nent, referrals, counseling ser						
		•	all required and recommende		ess otherwise specified.						
			do <u>NOT</u> want your child to re tion from a vaccine? <b> </b>			·					
	rius your cima c	.ver ridd a seriods react	ilon nom a vaccine. Lino	res ii so, what		•					
isease	•	Vaccine	Disease	Vaccine	Disease	Vaccine					
olio		IPV**	Measles	MMR**	Influenza/Flu	Influenza Vaccine					
hicker		Varicella**	Mumps	MMR**	CHILDREN LINDER	E VEARCOLD					
epatit etanus		Hep B** Tdap/Td/Dtap**	Rubella  Meningococcal	MMR** MCV4	CHILDREN UNDER Severe Diarrhea	5 YEARS OLD Rotavirus					
ctarius	3	Τααρ/Τα/Εταρ	Meningitis	IVICV4	Severe Diarrilea	Notaviius					
iphthe	eria	Tdap/Td/Dtap**	Human Papillomavirus	HPV9	Bacterial Disease	HIB					
ertuss	is	Tdap/Td/Dtap**			Pneumonia	PCV13					
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## Parent/Guardian Information

Nother/Guardian			DOB	Hor	me Phone	<del></del>	Alt Phone		
ather/Guardian			DOB Hon				Alt Phone		
arent(s)/Guardian Address	s								
arental Consent of Minor	Children: T	he follow	ing individu	als are permitte	d to bring my chil	d for treatment se	ervices:		
Name				Relationship	Name			Relat	
lealth Insurance (Pleas	e circle and co	omplete, if	f applicable)						
Medical Insurance: Private Insurance					Uninsured				
nsurance Policy Holder's N	nsurance Policy Holder's Name:				Insurance Poli	icy Holder's DOB:			
nsurance Policy Number _					Insurance Poli	icy Group Number			
ental Insurance:	Private In	surance	N	Medicaid	Uninsured				
nsurance Policy Holder's N	ame:				Insurance Poli	icy Holder's DOB:			
nsurance Policy Number					Insurance Poli	icy Group Number			
tudent's Health History	<u>L</u>								
rimary Care Physician:				Phone:			Date of Last Exam	:	
							Date of Last Exam:		
as your child ever been ho									
tudent/Family History	T		Τ		T	T			
Alachal/Davassas	Yes	No	Unsure	Age of onset	Student	Mom/Dad	Brother/Sister	Grandparent	
Alcohol/Drug use									
Anesthetic Allergy Anemia									
Artificial Heart Valve/Joint									
Asthma									
Blood Disorder/Sickle Cell Anemia									
Cancer									
Diabetes									
Depression/Anxiety									
Heart attack/Stroke <u>before</u> 55 years old									
Hemophilia	1		1						
High Blood Pressure	1				1				
Kidney Disease			1						
Learning Disability/special education									
Caacation									
Seizures/epilepsy									

Please add anything about your child's health that you feel would be helpful information that has not been inquired.