Erie County Health Department/Erie County Community Health Center

School Based Health Center Consent Form

______________________________ ______________________ ______________

Name of Student **Date of Birth** **Grade**

I understand that the Erie County Community Health Center will provide health services. One consent form per student must be signed annually and on file at the health center for the student to receive these services. By marking "yes" I consent to the following:

☐ **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 for my child to receive ☐ Medical Care and/or ☐ Mental Health* care through the School Based Health Center (examples: physical exams, evaluations of injuries, vaccines, chronic disease management, referrals, counseling services etc...)

☐ **Yes!** I consent for my child to receive all required and recommended vaccinations unless otherwise specified.
List the name(s) of any vaccine(s) you do *NOT* want your child to receive ___________________________________.
Has your child ever had a serious reaction from a vaccine? ☐ No ☐ Yes If so, what ________________________.

Disease	Vaccine	Disease	Vaccine	Disease	Vaccine
Polio	IPV**	Measles	MMR**	Influenza/Flu	Influenza Vaccine
Chicken Pox	Varicella**	Mumps	MMR**		
Hepatitis B	Hep B**	Rubella	MMR**	**CHILDREN UNDER**	**5 YEARS OLD**
Tetanus	Tdap/Td/Dtap**	Meningococcal Meningitis	MCV4	Severe Diarrhea	Rotavirus
Diphtheria	Tdap/Td/Dtap**	Human Papillomavirus	HPV9	Bacterial Disease	HIB
Pertussis	Tdap/Td/Dtap**			Pneumonia	PCV13

Vaccines marked with (**) are required for school.

☐ **Yes!** I consent for my child to receive **Dental Care** through the School Based Health Center.
(examples: cleanings, x-rays, sealants, fluoride, exams)

*****Parent/guardian of minor must be present for fillings, endodontic procedures and/or extractions**

I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, the School Based Health Center staff members will use and share Personal Health Information for 1.) Treatment of my child's health conditions and maintaining the continuity of my child's care, 2.) Payment for health services provided to my child, and 3.) Routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices documentation is available to me at the location(s) my child receives his/her health care services and on the Erie County Health Department/Erie County Community Health Center website.

______________________________ ______________________________ ______________

Parent/Guardian Signature **Print Name** **Date**

*Note: In accordance with Title X law, parental consent is *not* required for health services for individuals age 14 and older for medical treatments for venereal disease or HIV, diagnosis of pregnancy, or preventative services.

I hereby authorize the release of medical records to and from the following facilities to assist in the treatment and/or for continuity of care of my child: (check all that apply)

☐ The school to release records on a "need to know basis" to the School Based Health Center. (example: immunization record, class schedule, parental contact, address, phone number, medical/behavioral health conditions, health screenings, medications, health care plans, attendance information, etc.)

☐ My child's primary care physician to release any requested records to the School Based Health Center.
Physician's Name/Office ______________________________ Phone Number ____________________________

☐ My child's dentist to release any requested records to the School Based Health Center.
Dentist Name/Office ______________________________ Phone Number ____________________________

☐ The School Based Health Center to release records to my child's primary care physician and/or dentist as listed above.

______________________________ ______________________________ ______________

Parent/Guardian Signature **Print Name** **Date**

Parent/Guardian Information

Mother/Guardian ______________________ DOB______________ Home Phone ______________________ Alt Phone ____________________
Father/Guardian ______________________ DOB______________ Home Phone ______________________ Alt Phone ____________________
Parent(s)/Guardian Address ____

Parental Consent of Minor Children: The following individuals are permitted to bring my child for treatment services:

Name	Relationship	Name	Relationship

Health Insurance (Please circle and complete, if applicable)

Medical Insurance: Private Insurance Medicaid Uninsured
Insurance Policy Holder's Name: _________________________________ Insurance Policy Holder's DOB: _________________________
Insurance Policy Number _______________________________________ Insurance Policy Group Number ________________________

Dental Insurance: Private Insurance Medicaid Uninsured
Insurance Policy Holder's Name: _________________________________ Insurance Policy Holder's DOB: _________________________
Insurance Policy Number _______________________________________ Insurance Policy Group Number ________________________

Student's Health History

Primary Care Physician: _______________________________ Phone: _________________________________ Date of Last Exam: _______________
Primary Dentist:_____________________________________ Phone: _________________________________ Date of Last Exam: _______________

Allergies to medications, foods, bee stings, etc.….: ____
Current medications child is taking:
____

Important health history: (Pregnant, history of cancer, tumors, seizures, diabetes, tuberculosis, and heart murmurs, etc...)
____

Has your child ever been hospitalized overnight in the past year? ☐ Yes ☐ No If yes, why? ____
Has your child had surgery in the past year? ☐ Yes ☐ No If yes, please describe: ____

Student/Family History

	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 **before** 55 years old								
Hemophilia								
High Blood Pressure								
Kidney Disease								
Learning Disability/special education								
Seizures/epilepsy								
Tobacco use								
Tuberculosis/lung disease								

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