SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Saint Martin de Porres High School partners with The MetroHealth System ("MetroHealth") to offer School-Based Supplemental Health Services. Completion of this consent for treatment form (the "Consent Form") is required for your child to receive supplemental health services. **School nursing and emergency services will be provided whether or not you choose to take part in these added services.**

SAINT MARTIN DE PORRES
CLEVELAND'S CRISTO REY HIGH SCHOOL

MetroHealth

Student/Patient Information		
Student Last Name:	Student First Name:	
Date of Birth:	Sex (please x box): ☐ Female or ☐ Male	Social Security #:
Home Address:		City:
State: Zip Code:		Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic (please x box)? ☐ Yes or ☐ No	
Race (please x box): ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Native American/Pacific Islander ☐ Caucasian ☐ Declined ☐ Other:		
Name of Primary Care Provider/Physician (PCP):		
PCP Location (please x box): ☐ Care Alliance ☐ Cleveland Clinic ☐ MetroHealth ☐ Neighborhood Family Practice ☐ NEON ☐ UH/Rainbow Babies and Children ☐ Other:		
Legal Guardian Information		
Guardian's Last Name:	Guardian's First Name:	
Date of Birth:	Social Security #:	
Home Phone:	Cell Phone:	
Employer:	Employer Phone:	
Student/Patient Insurance Information		
Child/Teen has insurance (please circle): ☐ Yes or ☐ No		
Name of Insurance Company:	Subscriber's Name:	
Group Number:	Subscriber ID:	
Emergency Contact Information		
Name:	Relationship:	
Phone Number:	May we leave a message? ☐ Yes or ☐ No	

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

Patient/Student Medical History (please x all that apply)

☐ Asthma	☐ Cancer/Leukemia	☐ Eczema	☐ Migraines
☐ Premature Birth	☐ Sickle Cell	☐ Spine Disorders	☐ Bladder/Urinary Problems
☐ Seizures	☐ Glasses/Contacts	☐ Hearing Aids	☐ Mental Health Issues
☐ Blood Disorder	☐ Diabetes	☐ Pneumonia	☐ Kidney/Renal Disease
☐ Heart Problem	☐ Development Problems	☐ Bowel Issues/Constipation	☐ Tuberculosis/TB

☐ Other (Please explain):

Patient/Student Current Medications (vitamins, inhalers, prescriptions, other)

Name of Medication	Dose	Amount Taken	Times per Day

Preferred Retail Pharmacy Name:

Address:	Phone Number:

Patient/Student Allergies

□ **YES** – Please list below:	□ **NO KNOWN ALLERGIES**
Food:	
Medications:	
Insects:	
Seasonal:	
Animals:	

Immunization History

Has your child every had a reaction to any immunizations/shots? ☐ Yes or ☐ No

If YES, please explain reaction:

What immunization/shot caused reaction:

Patient Hospital/Surgery History

Past Hospital Stays: ☐ Yes or ☐ No	Explain:
Past Surgeries: ☐ Yes or ☐ No	Explain:
ER visits in past year: ☐ Yes or ☐ No	How many:

Family History (please X all that apply) and list who has the problem next to it (mom, dad, grandparent, brother, sister)

☐ Anemia		☐ High Blood Pressure	
☐ SIDS/Sudden Infant Death		☐ Asthma	
☐ Headaches		☐ Stroke	
☐ Diabetes		☐ Alcohol / Drug Abuse	
☐ AIDS/HIV		☐ Cancer	
☐ Arthritis		☐ High Cholesterol	
☐ Heart Disease		☐ Seizures	
☐ Sickle Cell		☐ Tuberculosis/TB	
☐ Mental Health Issues		☐ Other (please list)	

School-Based Supplemental Health Services Consent Form

The purpose of this Consent Form is to allow parents/guardians/emancipated minors/students over the age of 18 to:

(1) give informed consent for your child to participate in and receive treatment from a MetroHealth physician or healthcare provider through its School Health Program with or without the presence of a parent/guardian;
(2) acknowledge that care may be provided in-person or by telehealth. The main difference between telehealth and in-person care is the provider's inability to have direct, physical contact with the patient. Also, the quality of telehealth transmission might affect the quality of healthcare services. The patient may stop using telehealth at any time without jeopardizing access to future care, services or benefits.
(3) acknowledge responsibility for the payment of charges and fees not covered by insurance;
(4) give permission to release your child's protected health information ("PHI") from MetroHealth to staff at St. Martin and the School Wellness Center involved in the operation and administration of its health program, including but not limited to nurses, physical therapists, occupational therapists, speech therapists, psychologists, social workers, health coordinators, and administrative staff (collectively, "St. Martin Health Personnel") for purposes of treatment and care coordination; and
(5) give permission for St. Martin staff to release your child's medical information and other relevant personal information to MetroHealth to facilitate the assessment of your child's health needs, coordinate your child's care, provide treatment or referral, and/or evaluate the School Health Program and the services provided.

Consent for Health Services/Treatment

By signing below, the Parent/Guardian consents for your child to receive the necessary and/or advisable School-Based Supplemental Health Services listed below in this section of the Consent Form (the "Service") from a MetroHealth physician or healthcare provider through MetroHealth's School Health Program. The Parent/Guardian understands that he/she has the opportunity to ask and have any questions answered about the risks, benefits, and alternatives of the Services by contacting MetroHealth at (216) 957-1303 and that MetroHealth recommends the Parent/Guardian do so prior to signing this Consent Form if he/she has any questions about the Services. The Parent/Guardian further understands that examination and treatment may be in-person or by telehealth. The Parent/Guardian acknowledges and understands that by signing this Consent Form, he or she is consenting to the Services and/or immunizations directly below. **If there are particular services or immunizations you do not want your child to have, please circle those services.**

(Circle any services or immunizations you DO NOT want your child to receive.)

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Routine lab tests
- Prescription medications
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems, reproductive health)
- Care of certain chronic conditions (such as asthma,
  - seizure disorders, or diabetes)
- Mental/behavioral health assessment, screening,
  - and intervention (parental/guardian consent required for children under the age of 14)
- Vision and hearing screening and follow-up services
- Dental screening and services (exam, sealants, fluoride)
- Health education and prevention programs
- Sports medicine services

Immunizations (Shots)

Your school nurse and the School Health Program team will review your child's record to determine which shots are needed.

School Required Immunizations:

☐ DTap/Td ☐ Tdap ☐ Polio ☐ Hepatitis B
☐ MMR (Measles, Mumps, Rubella) ☐ Meningococcal A
☐ Varicella (Chicken Pox)

Pediatric/Adolescent Recommended Immunizations:

☐ Human Papillomavirus (HPV) ☐ Influenza (Flu)
☐ Hepatitis A ☐ Meningococcal B

Please visit **http://www.immunize.org/vis/** to find the Vaccine Information Statement for each vaccine, which will explain risks and benefits of all vaccines.

Agreement of Financial Responsibility

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. If applicable, MetroHealth will bill your child's insurance carrier(s) for charges and fees covered by your child's insurance plan. Parent/Guardian agrees to provide complete, accurate and timely information relating to any available health insurance in order for MetroHealth to seek payment in a timely manner. Parent/Guardian understands that a failure to provide complete, accurate and timely information, including any changes in insurance coverage, may prevent the provider from complying with the administrative rules of your child's insurance plan. Parent/Guardian may obtain a list of usual and customary charges from MetroHealth upon request.

I, PARENT/GUARDIAN, CERTIFY THAT I AM OF SOUND BODY AND MIND, THAT I HAVE READ THIS CONSENT FORM, THAT I HAVE RECEIVED INFORMATION ON THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, INCLUDING THE PROCESS FOR FILING A COMPLAINT OR GRIEVANCE, THAT I UNDERSTAND AND AGREE WITH THE INFORMATION CONTAINED IN THIS CONSENT FORM, INCLUDING BUT NOT LIMITED TO THE CONSENT FOR HEALTH SERVICES/TREATMENT AND FINANCIAL RESPONSIBILITY SECTIONS, AND THAT I FREELY GIVE MY INFORMED CONSENT FOR MY CHILD TO RECEIVE THE RECOMMENDED SUPPLEMENTAL HEALTH SERVICES.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____ **Date:** _____

(TURN OVER FOR ANOTHER SIGNATURE)

*Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.

Authorization to Release Health Information

I authorize MetroHealth to provide my child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to St. Martin Health Personnel for treatment, referral, and/or care coordination. To help coordinate care, I also authorize St. Martin staff to provide a copy of medical information or other relevant personal information within my child's school records to MetroHealth to facilitate the assessment of my child's health needs, coordinate my child's care, provide treatment or referral, and/or evaluate the School Health Program and its services. I also agree to allow MetroHealth access to my child's individual academic, attendance, and behavior records for the current and prior school years so it can provide better services to my child. This permission will expire when your child is no longer an enrolled student at St. Martin or when it is terminated in writing.

I understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If you have consented for your child to be tested, treated, or diagnosed with any such injury, disease, or illness, MetroHealth is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For records related to alcohol and drug treatment, federal law prohibits recipient from making further disclosure of this information unless the additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal law.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my child's health information, it will not in any way prevent my child from receiving care or treatment from MetroHealth or appropriate St. Martin Health Personnel I understand that I may terminate this authorization in writing at any time, prior to the release of my child's health information.

I am aware there is potential for information disclosed under this consent to be redisclosed by the recipient and no longer be protected.

Notice of Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices if my child is a new patient at The MetroHealth System. I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for The MetroHealth System if my child has been a patient at The MetroHealth System in the past. I know that I can also view them online:

The MetroHealth System:
https://www.metrohealth.org/patients-and-visitors

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CONSENT TO THE RELEASE OF MY CHILD'S INFORMATION AS DESCRIBED IN THE ABOVE AUTHORIZATION.

I, PARENT/GUARDIAN, ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS CONSENT.

THIS CONSENT FORM WILL REMAIN VALID WHILE PARTICIPANT IS ENROLLED IN SAINT MARTIN DE PORRES HIGH SCHOOL OR UNTIL TERMINATED IN WRITING.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____

Date: _____

Student Name:	**Student DOB:**	**Student School:**

*Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.