SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Urban Community School ("UCS") partners with The MetroHealth System ("MetroHealth") to offer School-Based Supplemental Health Services. Completion of this 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.**

UCS Urban Community School

MetroHealth Devoted to Hope, Health, and Humanity

Student/Patient Information			
Last Name: First Name:			Social Security #:
Date of Birth:	Sex (please x): ☐ Female ☐ Male		Gender (please x): ☐ Female ☐ Male ☐ Other
Home Address:			City:
State: Zip Code:			Phone Number:
School Name:		Preferred Language:	
Do you identify as Hispanic (please x)? ☐ Yes ☐ No	Race (please x): ☐ American Indian/Alaskan Native ☐ Native American/Pacific Islander ☐ Caucasian ☐ Asian ☐ African American ☐ Declined ☐ Other:		
Primary Care Provider		Preferred Pharmacy	
Name:		Name:	
Location (please x): ☐ NEON ☐ MetroHealth ☐ Care Alliance ☐ Cleveland Clinic ☐ Neighborhood Family Practice ☐ UH/Rainbow Babies and Children ☐ Other:		Address:	Phone Number:

Legal Guardian Information	
Last Name: First Name:	
Date of Birth:	Social Security #:
Home Phone:	Cell Phone:
Employer:	Employer Phone:

Student/Patient Insurance Information	
Child/Teen has insurance (please x): ☐ 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 ☐ Bladder/Urinary Disorder ☐ Blood Disorder ☐ Bowel Disorder ☐ Cancer/Leukemia ☐

Depression/Anxiety ☐ Developme ntal Disorder ☐ Diabetes ☐ Eczema Migraines ☐ Glasses/Contacts ☐

Hearing aids ☐ Heart Disorder ☐ Kidney/Renal Disorder ☐ Pneumonia ☐ Seizures ☐

Tuberculosis/TB ☐ Bowel Issues/Constipation ☐ Other (Please explain):

Patient/Student Allergies	**Immunization History**
□ **NO KNOWN ALLERGIES** □ **YES** – Please list below:	Has your child every had a reaction to any immunizations/shots? ☐ Yes or ☐ No
Medications:	If yes, please explain reaction:
Food: Seasonal:	
Insects: Animals:	What immunization/shot caused reaction?

Consent for Health Services/Treatment

By signing below, I consent for my child to receive the School-Based Supplemental Health Services (the "Services") listed below when necessary to promote my child's health. I understand that these Services will be performed by a MetroHealth provider through MetroHealth's School Health Program. I also understand that examination and treatment may be in-person or by telehealth. Treatment received using telehealth does not allow for direct contact with a patient and may be affected by transmission quality. If I no longer want my child to receive telehealth services, I may request that they be stopped, and that request will not affect my ability to obtain medical care for my child in the future. I understand that I can ask any questions about the Services by contacting MetroHealth at (216) 957-1303.

MetroHealth's School Health Program may provide the following services unless you tell us not to. Please X out any services or immunizations that you <u>DO NOT</u> want your child to receive.

- ☐ Physical exams (well-child, sports, work)
- ☐ Care and treatment for injury/illness
- ☐ Medication administration (albuterol, epinephrine, antibiotics, prescription and over-the-counter medications)
- ☐ Routine lab tests
- ☐ Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- ☐ Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- ☐ Mental/behavioral health assessment, screening, and intervention
- ☐ Sexual wellness services
- ☐ Vision and hearing screening and treatment
- ☐ Dental screening and services (dental x-rays, sealants, and cleanings; therapeutic fillings, fluoride applications)
- ☐ 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.

<u>School-Required Immunizations:</u>

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

<u>Pediatric/Adolescent Recommended Immunizations:</u>

☐ 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 to learn more about the risks and benefits of all vaccines.

Agreement of Financial Responsibility

Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. If applicable, I agree to provide complete, accurate and timely information relating to any available health insurance in order for MetroHealth to seek payment in a timely manner. These Services are provided to families whether or not a student has insurance or the ability to pay. I give MetroHealth 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 Health Program.

I have read and understand the information about the School-Based Supplemental Health Services provided through the MetroHealth School Health Program. My signature provides consent for my child to receive the Services for as long as my child is a student in UCS. I understand that I can revoke my consent at any time by providing a written request to _____.

Signature of Parent/Legal Guardian (or student if 18 years or older or otherwise permitted by law): _____

Printed Name: _____

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

Authorization to Release Health Information

I authorize MetroHealth to provide my child's medical information, including diagnosis, treatment records, vaccinations, and lab results, to UCS staff involved in the operation, administration, and evaluation of its health program. These UCS staff may include nurses, physical therapists, occupational therapists, speech therapists, psychologists, social workers, health coordinators, researchers, and other administrative staff (together, the "UCS Health Personnel"). MetroHealth's communications with UCS Health Personnel will be made to help with my child's treatment, referral, and care coordination and to assist with evaluation of the School Health Program and its services.

I also authorize UCS staff to provide a copy of medical information or other relevant personal information within my child's school records to MetroHealth so MetroHealth can better understand my child's health needs, coordinate my child's care, provide treatment or referral, and evaluate the School Health Program and its services. The information UCS provides to MetroHealth may include access to my child's individual academic, attendance, and behavior records.

I understand that my child's 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 drug or alcohol abuse treatment. MetroHealth may only disclose information relating to such diagnosis, testing, or treatment as directed in this authorization and as allowed under applicable law.

I understand that I am not required to sign this authorization, and I do so of my own free will. If I refuse to sign this authorization, it will not in any way prevent my child from receiving care or treatment from MetroHealth or appropriate UCS 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 also aware there is potential for information disclosed under this authorization to be redisclosed by the recipient and no longer be protected.

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for The MetroHealth System. I know that I can also view them online at: https://www.metrohealth.org/patients-and-visitors. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting The MetroHealth System by phone or in writing. I understand I have the right to ask how my protected health information will be used or given out.

I CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CONSENT TO THE RELEASE OF MY CHILD'S INFORMATION AS DESCRIBED ABOVE. I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS DOCUMENT.

THIS AUTHORIZATION FORM WILL REMAIN VALID WHILE MY CHILD IS ENROLLED IN UCS OR UNTIL I TERMINATE IT IN WRITING.

Signature of Parent/Legal Guardian (or student if 18 years or older or otherwise permitted by law): _____

Printed Name: _____

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

Student Name:	Student DOB:	Student School:	