SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Cleveland Metropolitan School District partners with many community agencies to offer School-Based Supplemental Health Services. Completion of this consent for treatment 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**. Some Supplemental Services may not be available at all CMSD school buildings. (Check with your school nurse for questions about services availability).

Student/Patient Information		
Student Last Name: Student First Name:		
Date of Birth:	Sex (please circle): Female or Male	Social Security #:
Home Address:		City:
State: Zip Code:		Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic (please circle)? Yes or No	
Race (please circle): American Indian/Alaskan Native Asian Native American/Pacific Islander Caucasian African American Declined Other:		
Name of Primary Care Provider/Physician (PCP):		
PCP Location (please circle): 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 circle 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 circle 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 and/or Care Alliance Health Center physician or healthcare provider through its School Health Program with or without your presence;
(2) acknowledge responsibility for the payment of charges and fees not covered by insurance; and
(3) give permission to release your child's protected health information ("PHI") from The MetroHealth System (MetroHealth) and/or Care Alliance Health Center to the Cleveland Metropolitan School District School Medical Staff (Nurses, Physical Therapists, Occupational Therapists, and Speech Therapists).

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 and/or Care Alliance Health Center physician or healthcare provider through MetroHealth's or Care Alliance Health Center'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 Care Alliance at (216)535-9100 Ext 285 or MetroHealth at (216)957-1303 and that MetroHealth and/or Care Alliance Health Center recommends the Parent/Guardian do so prior to signing this Consent Form if he/she has any questions about the Services. 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 <u>DO NOT</u> 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)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Sexual health services (such as, reproductive counseling including contraception)
- 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 If needed
- Dental screening and services (exam, sealants, fluoride) if needed
- 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 · Hepatitis B
· MMR (Measles, Mumps, Rubella) · Meningococcal A
· 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, which will explain risks and benefits of all vaccines.

Agreement of Financial Responsibility

If applicable, MetroHealth and/or Care Alliance Health Center 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 and/or Care Alliance Health Center 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 Practice and/or Care Alliance Health Center 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 ABOVE IN THE CONSENT FOR HEALTH SERVICES/TREATMENT AND FINANCIAL RESPONSIBILITY SECTIONS OF THIS FORM, 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)

[1]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.

Release of PHI

I authorize MetroHealth and/or Care Alliance Health Center to provide my Child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to Cleveland Metropolitan School District School Nurses for treatment, referral and/or care coordination. To help coordinate care, MetroHealth and/or Care Alliance Health Center may receive and copy medical information within Child's school records via assistance from Cleveland Metropolitan School Nurses.

This permission will expire when your Child is no longer an enrolled student in the Cleveland Metropolitan School District or when it is terminated in writing.

I understand that my express consent (including your child's) may be required for the disclosure of information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If your Child has been tested, treated, or diagnosed with any such injury, disease, or illness, MetroHealth and/or Care Alliance Health Center 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 PHI, it will not in any way prevent Participant from receiving care or treatment from MetroHealth and/or Care Alliance Health Center. I understand that I may terminate this authorization in writing at any time, prior to the release of my Child's PHI.

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 and/or Care Alliance Health Center. I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for The MetroHealth System and/or Care Alliance Health Center at any of the School Health Program sites if my child has been a patient at The MetroHealth System and/or Care Alliance Health Center in the past. I know that I can also view them online:

The MetroHealth System:
http://www.metrohealth.org/upload/docs/main/Patient%20Visitor%20Information/VII-07BNoticeofPrivacyPractices.pdf
Care Alliance Health Center
http://www.carealliance.org/wp-content/uploads/2016/05/Notice-of-Privacy-Practices-FY-2016.pdf

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS CONSENT TO RELEASE PHI AND CONSENT TO THE RELEASE OF MY CHILD'S PHI TO CLEVELAND METROPOLITAN SCHOOL DISTRICT SCHOOL NURSES.

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 THE CLEVELAND METROPOLITAN SCHOOL DISTRICT 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:**

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