**GENERAL CONSENT FOR CLINICAL SCHOOL HEALTH SERVICES**

*STRICTLY CONFIDENTIAL ~ FOR HEALTHCARE USE ONLY*

**PRINT THE FOLLOWING INFORMATION FOR THE STUDENT – PATIENT**

**STUDENT NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**D.O.B**.\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ **SEX**: M\_\_\_\_\_ F \_\_\_\_\_ **STUDENT ID**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY –** *Check all that applies*.

**ASTHMA \_\_\_ DIABETES\_\_\_\_\_ SEIZURE\_\_\_\_\_ SEVERE ALLERGY\_\_\_\_\_ OTHER \_\_\_\_ (please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST HOSPITALIZATIONS/SURGERIES:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Primary Care Physician** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone **#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF STUDENT has insurance coverage, please complete the following information:**

**MEDICAID #**\_\_\_\_\_\_\_\_\_\_\_\_\_ **KIDCARE #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIVATE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHECK THE NAME OF YOUR CHILD’S HEALTH INSURANCE PLAN:**

**Amerigroup \_\_\_ Children's Medical Services \_\_\_ Coventry \_\_\_ Humana \_\_ Molina\_\_ Preferred Medical\_\_\_\_\_**

**Prestige \_\_\_ Simply \_\_\_ Staywell \_\_\_ Sunshine \_\_\_\_ United Healthcare\_\_\_\_ Magellan \_\_\_\_ Other \_\_\_\_\_**

**CLINICAL SCHOOL HEALTH SERVICES**

The School Health Team MAY provide the following services, if needed or requested. **PLEASE CIRCLE**all services you **would like** your child to receive.

Physical exams Dental Screening Adolescent Health Services\*

Blood tests Health Screening, Diagnosis and Treatment Gynecologic Services\*

Urine tests Immunizations / Vaccinations Family planning services and education\*

Tuberculosis testing Nutrition Evaluation and Consultation Behavioral Health Services

\*These services may be provided at Middle and Senior High Schools only. Students will be referred to their Primary Care Physician where appropriate.

**General Consent for School Health Services and Treatment**

By signing below, I consent and authorize the (Name of provider), the nurses and clinical personnel of the school health team to provide school health services and treatment to the above named Student, including any physical examination, laboratory and diagnostic tests, injections/vaccines, or any other school health service or treatment which in their professional judgment is necessary or recommended for the diagnosis and treatment of any medical condition for the student named above, WITH THE EXCEPTION of those specific School Health Services above that are not circled.

I understand that the results of medical information obtained while my child receives treatment at the school health facility is confidential and will not be disclosed to anyone without my written permission or a court order as required by applicable federal and state laws. I understand Florida laws require the school healthcare team to provide the Department of Health with a report of those individuals diagnosed with communicable diseases. Therefore, I authorize the school healthcare team to report to the Department of Health whenever my child is diagnosed as having a communicable disease. I further understand that my child and/or I will be notified of any such diagnosis. Without written notification to change my preferences related to my child’s treatment, I understand that this consent expires on the date that my child is no longer enrolled in the school.

I consent to the use and release of medical information as necessary for treatment, payment and healthcare operations of the school health team, including to the treating provider, guarantor of accounts, or third party payors for which I have assigned benefits or which may otherwise reimburse for the provision of services, and if requested to my primary care physician or any other healthcare provider for purposes of continuity of care.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_am related to the Child as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name) (Mother, father, legal guardian)

I am legally authorized to sign this document \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of parent / legal guardian)

Daytime phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_