

**Weldon City School Based Health Center
School Parental Consent Form (Grades PK-12)**

Office Use Only

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p>Student's Last Name: _____</p> <p>Student's First Name: _____</p> <p>Date of Birth: _____ / _____ / _____ <i>Month Day Year</i></p> <p>Student's Social Security Number: _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Grade _____</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>Student Address: _____ _____ _____ <i>City State Zip Code</i></p> <p>Who is the student's regular doctor? Name: _____ Telephone: _____ Address: _____ _____</p> <p>Last Visit Date: _____</p>	<p>Mother Last Name: _____ First Name: _____</p> <p>Father Last Name: _____ First Name: _____</p> <p>Legal Guardian, If Applicable Last Name: _____ First Name: _____ Relationship of legal guardian to student <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or Uncle <input type="checkbox"/> Other: _____</p> <p>Contact Information for parent or guardian Home Tel: _____ Work Tel: _____ Beeper/Cell: _____</p> <p>Additional Emergency Contact Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____ Beeper/Cell: _____</p>

INSURANCE INFORMATION

<p>Does your child have Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <p>Medicaid ID # _____</p> <p>Carolina Access Provider: _____</p>	<p>Does your child have other insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes:</p> <p>Insurance Company: _____</p> <p>If your child does not have health insurance, would you like to be contacted regarding a sliding fee program? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the RURAL HEALTH GROUP & WELDON CITY'S SCHOOL BASED HEALTH CENTER.

NOTE: Minors' consent law. G.S. 90-21.5(a) allows physicians to accept unemancipated minors' consent for treatment under certain circumstances.

1. An unemancipated minor may give effective consent for his or her own treatment for the prevention, diagnosis, or treatment of any of the following conditions:

- a. venereal diseases and other reportable communicable diseases,
- b. pregnancy,
- c. abuse of controlled substances or alcohol, or
- d. emotional disturbance.

My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified. I consent to having my child's medical information shared with my normal pediatrician who is: _____.

X _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) **Date**

**Weldon City School Based Health Center
School Parental Consent Form**

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of RURAL HEALTH GROUP AND WELDON CITY'S SCHOOL BASED HEALTH CENTER as part of the school health program. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. Annual health questionnaire/survey.

**WELDON CITY SCHOOL DISTRICT
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION**

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Weldon City School District, either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the RURAL HEALTH GROUP AND WELDON CITY SCHOOL BASED HEALTH CENTER to release specific medical information of the student named on the reverse page.

I consent to the release from the School-Based Health Center to Rural Health Group and from Rural Health Group to the School-Based Health Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

- Information Required by Law or Chancellor's Regulation:**
- Immunizations
 - Vision and hearing screening results
 - Tuberculin test results
- Information to Protect Health and Safety:**
- Conditions which may require emergency medical treatment
 - Conditions which limit a student's daily activity
 - Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
 - Health insurance coverage

My signature on this form also gives my consent to RURAL HEALTH GROUP AND WELDON CITY SCHOOL BASED HEALTH CENTER to contact other providers that have examined my child and to obtain insurance information.

X _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) _____ **Date** _____

Time Period During Which Release of Information is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the SBHC