CONSENT FOR SCHOOL HEALTH SERVICES
2014-2015 KNOX COUNTY SCHOOL DISTRICT AND FAMILY HEALTH CARE ASSOCIATES OF BARBOURVILLE

SCHOOL:_____ TEACHER:_____ GRADE:_____

Student's Last Name_____ First Name_____ MI ____
(Please give child's complete legal name)

Student's Social Security #_____ **Birth Date**_____

Male ___ Female___ Race:_____ How many people live in the home:_____

___**Yes, I give my consent for my child** _____**to receive services at the School Clinic.**
NAME OF STUDENT

___**No, I do not wish my child,** _____**to receive services at the School Clinic.**
NAME OF STUDENT

By signing this consent I release the Barbourville School District/Board of Education and Family Health Care Associates of Barbourville from any liability related to the administration of medication or treatment so long as Reasonable and Customary care is provided.

This consent is to allow your child to see the school nurse for injuries, illnesses, and required health screenings while at school. This does not replace your primary health care provider. It merely gives permission to be seen by the school nurse.

If you do not complete this form and return it to your child's teacher at the school site the Nurse will not be allowed to care for your child EXCEPT in a true emergency situation.

Street Address:_____ City_____ Zip_____

Mother's Name_____ Hm Ph_____ Wk Ph. _____ Cell Ph_____

Father's Name_____ Hm Ph _____ Wk Ph _____ Cell Ph_____

Legal Guardian_____ Hm Ph _____ Wk Ph _____ Cell Ph _____

Free or Reduced Lunch Yes No Food Stamps Yes__ No__ KTAP Yes__ No__

EMERGENCY CONTACT: (cannot be the same as those listed above)

Name of Emergency Contact	Home Phone	Work Phone	Cell Phone	Relationship to Student

Student's Medical Insurance

KY Medical Card Yes No Provider Number:_____ MCO Provider _____
K-Chip Card Yes No Provider Number:_____
Health Insurance Yes No Company:_____ Policy #:_____

Student's Medical History

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

____Measles	____Scarlet Fever	____Joint or Muscle Pain or Stiffness	__ADD/ADHD
____Mumps	____Seizures	____Exposed to Tuberculosis	
____Anemia	____Unexplained Weight Loss	____Shortness of Breath	
____Birth Defects	____Unexplained Tiredness	____Head, Eyes, Ears, Throat Problems	
____Diabetes	____Persistent Cough	____Blood Transfusion	
____Chicken Pox	____Unexplained Weight Gain	____Anaphylactic Episodes	
____Rheumatic Fever	____Leukemia	____Chest Pain	
____Asthma	____Sleep Problems	____Stomach or Bowel Problems	

If you answered yes to any of the above please explain:_____

_____

Please specify if any of the student's family members have had any of the listed health problems by using this code: S-Sibling, F-Father, M-Mother, GF-Grandfather, GM-Grandmother and also identify the Grandparent by P-Paternal or M-Maternal (example: the mother's parents would be listed as MGF for Maternal Grandfather)

____Cancer ____Anemia ____Kidney Disease ____Tuberculosis ____Heart Disease ____Birth Defects ____Epilepsy
____ Stroke ____ High Blood Pressure ____Diabetes

Student's Medications taken on a regular basis_____

You will be asked to complete a separate Medication Consent form if you desire the School Nurse to administer this medication in the School.

Student's doctor:_____ Address _____

Student's dentist:_____ Address:_____

Student's Pharmacy:_____ Address:_____

_____Any Operations (if so please specify)_____

Type Surgery Where Physician Date

_____Any Hospitalizations (if so please specify)_____

Reason Where Physician Date

_____Any serious injuries or illnesses (if so please specify)_____

Type of Injury or Illness Physician Date

When was the last time your child was seen by a doctor?_____

Doctor's Name Reason Date

Student's allergy to **FOOD, MEDICATIONS OR ENVIRONMENTAL POLLENS?** Yes__ No__

IF YES, PLEASE LIST:_____

Does your child use any of the following substances: **Tobacco** Yes__ No__ **Alcohol** Yes__ No__ **Drugs** Yes__ No__

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The following list of medications will be on hand at the School Clinic and may be administered **only** by the **School Nurse** after she has evaluated your child's complaint. Please review the following list of medications and place a (√) by the ones you will allow your child to have:

Acetaminophen (Generic name for Tylenol)	____	Ibuprofen (Generic for Advil and Motrin)	____
Aloe Vera Gel	____	Orajel/Orasol	____
Blistex	____	Sore throat spray	____
Calamine Lotion	____	Refresh Plus Eye Drops	____
Cough Drops (Menthol)	____	Triple antibiotic ointment	____
Diphenhydramine (Generic name for Benadryl)	____	Hydrocortisone 1% Cream	____
Tussin DM (Age 12 or older)	____	Hydrogen Peroxide (for wound cleansing)	____
Children's Pepto/Calcium Carbonate (Tums)	____		

Consent for Health Services/Assignment of Benefits

I consent to care which may include screening, assessments, lab test, treatment, first-aid, over the counter and/or prescription medicine, and any other health service given to my child by staff or agents of Family Health Care Associates. I authorize the school health clinic staff to release medical information about my child that impacts learning environment to his/her physician/primary care provider, school principal/ guidance counselor or designee. I also understand that the information obtained for the school physical including immunization information will be released to my child's school. If my child has Medicaid/K-Chip, I authorize payment to be made to Family Health Care Associates on my behalf, for services received. I also release this information to Medicaid/K-chip for billing purposes or visits to the school health clinic. I understand that no guarantees are being made as to the effects of any exam or treatment on my child. I further understand that I will not be billed for any services that my child receives at the school clinic during the school session except for vaccines that are not required (i.e. flu vaccine, a separate consent form would be sent home). I acknowledge receipt of the Notice of Privacy Practices (NPP) and Bill of Rights. I request that payment of authorized medical insurance benefits be made to Family Health Care Associates of Barbourville on my behalf for services rendered to my child. I also authorize the local school district to release medical information about me to Medicaid, Medicare, insurance and/or other third party payers' to determine payment for services. I have read this statement and understand that my signature indicates that I do consent and assign benefits as stated above. I also authorize Family Health Care Associates Nurse providing services at the school clinic to provide health information from my child's medical record to and from the designee of the school and my child's physician only as needed under the guidelines of HIPPA and FERPA consistent with Federal Laws for the purpose of providing safe and appropriate school health services and programs.

I certify that the information I have submitted is correct.

Parent/Legal Guardian Signature_____ DATE_____