

SCHOOL-BASED PEDIATRIC CONSENT FORM

I understand that Whitefoord Inc. School Based Health Centers can provide comprehensive health services to my child. **I also understand that I have the right to withdraw this consent at any time upon written notice to the medical director.**

I authorize (check all that applies):

- Release of information** from the child’s medical record whenever necessary for payment, continued care or treatment, and healthcare operations.
 - I further give consent for staff to examine the child’s full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.
- For my child to receive **medical care** through the School Based Health Center, including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, referrals and other office minor procedures.
 - Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian**
- For my child to receive **dental care** through the School Based Health Center. This includes periodic dental examinations for my child, which may include screenings, photographs, radiographs, and any other acceptable methods for the dental evaluation and management of the child’s dental health.
- For my child to receive **behavioral health and counseling services**, including one-on-one counseling, community resource referrals and outreach, and coordination of outside resources
- Participation in **health education** classes and the Fitness Program sponsored/coordinated by Whitefoord Inc. Health Education Department.
- That in the case of a medical emergency, I give permission to Whitefoord Inc. Health Centers to call **emergency transport** for my child.

In order for health center staff members to provide services, I authorize the school to release school records on a “need to know basis” to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into GRITS (Georgia Registry of Immunization Transactions and Services), dental and mental health records. I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child’s health condition and maintaining the continuity of my child’s care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services.

I have read and understand the above information and give permission for the child’s care as described. I understand that I have the right to OPT the child out of any medical testing or treatment. This consent will last the duration of the child’s time at this school location.

Name of Parent or Legal Guardian (please print):	Name of Child (please print):	
Signature of Parent or Legal Guardian:	Relationship to Child:	Date:

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PRESENT HEALTH CONCERN/REASON FOR VISIT: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____
Street Address/Apt #: _____ **County:** _____ **City:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Current Primary Care Provider (PCP): _____ Patient does not have one but would like to make Whitefoord PCP
Date of Birth (mm/dd/yyyy): _____ **Sex:** Male Female Transgender (M-to-F) Transgender (F-to-M)
Race: American Indian or Alaskan Native Asian Native Hawaiian Black White **Race Cont. :** Hispanic More than one race
 Other: _____ **Ethnicity:** Hispanic Non-Hispanic
Primary Language: _____ **Do you or the patient require a translator?** Yes No
Present Housing Situation (check any that apply): Migrant Seasonal Homeless Public Housing
Does this patient have an advanced directive (legal document stating patient's wishes regarding medical treatment if no longer able to communicate to doctor)? Yes No
How did you hear about Whitefoord? Please Specify: _____
Does Patient Attend School? Yes No **School Patient Attends:** _____ **Grade:** _____

PARENT/ GUARDIAN INFORMATION

Name: _____ **Relationship to Patient:** _____
Street Address/Apt # (If different from above): _____
Employer Name (if applicable): _____
Employment Status: Full Time Part Time Not Employed Self Employed Retired Active Military Unknown
Student Status: Full Time Part Time Not a Student **Email:** _____
If you are unavailable, do you authorize Whitefoord to discuss patient health information with anyone else?: Yes No
If yes, please provide: Name: _____ Relationship to Patient: _____ Phone #: _____
Emergency Contact (If different than Parent/Guardian):
Name: _____ **Relationship to Patient:** _____ **Phone #:** _____
Can Whitefoord discuss personnel health information with Emergency Contact? Yes No

INSURANCE AND FINANCIAL INFORMATION

Financially Responsible Party (financially responsible for payment or primary insurance holder): Self Other
If other, Name: _____ Relationship to patient: _____
What is financially responsible party's number of dependents?: _____
What is financially responsible party's estimated income? _____ Hourly Weekly Bi-weekly Monthly Yearly
Are you covered by medical insurance?: Yes No If yes, what type?: Medicaid Private Other: _____
If Medicaid: Medicaid ID #: _____
If Private Insurance: Company Name: _____ Policy Holder Name: _____
Policy #: _____ Group #: _____
Do you have dental insurance? Yes No
Company Name: _____ Policy Holder Name: _____
Policy #: _____ Group #: _____
Preferred Pharmacy Name: _____ **Preferred Pharmacy Phone Number:** _____
Preferred Pharmacy Address: _____

MEDICAL HISTORY

Was patient born premature? Yes No If Yes, explain _____
Has patient been treated or received care in an Emergency Room in the past 6 months? Yes No
Does patient take any medications? Yes No *List all medications:* _____

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Does he/she need to take any prescribed medications during school hours? Yes No *List all medications:*

Approximate date of last well check visit?

Date:

Any surgery in the past? Yes No Explain:

Any hospitalization in the past? Yes No Explain:

Any implanted medical device such as shunts, catheters, pacemaker etc ? Yes No If Yes, explain:

Has patient started their menstrual period? Yes No Start date:

Is premedication with antibiotics needed prior to dental procedures? Yes No Explain:

HAS THE PATIENT HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?:

Systems Review	Name of the Condition	Yes	No	Age of Onset	Family member with condition? (please specify)
Neurological (Brain) and Nerve disorders (ex. Migraines, Seizures)					
Eye disorders					
Ear/Nose/Throat disorders					
Oral/Dental disorders					
Endocrine/gland disease/autoimmune disorders (ex. Diabetes, Hyperthyroidism)					
Lung Disease/Problems (ex. Asthma, Pneumonia)					
Heart Disease/ Problems (ex. Hypertension)					
Gastro-Intestinal disorders (ex. Gallstones, Ulcers)					
Urinary Tract Disease/Problems (ex. Kidney stone, over active bladder)					
Skin disorders (ex. Psoriasis, Eczema)					
Blood /Lymph disorders (ex. Anemia)					
Allergy/Immunology disorders					
Behavioral Health problems/Mental Illness (ex. Depression, Eating Disorder)					
Musculoskeletal/Joint disorders (ex. Scoliosis)					
Developmental Disorders (ex. Autism)					
School/Psycho-social problems (ex. ADD)					
Cancer/Malignancy					
Others (ex. TB, Hepatitis, Chicken Pox)					

ALLERGIES

Any allergies? Yes No If yes, list all allergies (food, medications, anesthetic, latex, other):

Does your child have an Epi-Pen at school? Yes No

DENTAL HEALTH

Would you like to enroll the patient in dental services? Yes No

Has patient had dental cleaning within the last 6 months? Yes No

Are you currently experiencing any dental pain or discomfort? Yes No

BEHAVIORAL HEALTH: Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services? Yes No