Whitefoord, Inc.
Uniting Community through Health and Education

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.

<table>
<tr><td>Name of Parent or Legal Guardian (please print):</td><td colspan="2">Name of Child (please print):</td></tr>
<tr><td>Signature of Parent or Legal Guardian:</td><td>Relationship to Child:</td><td>Date:</td></tr>
</table>

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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: ____________

Responsible Party's Date of Birth (MM/DD/YYYY): ____________

We offer discount based on a sliding fee scale, giving us your household information would help us determine if you qualify for our sliding fee scale discount:

What is financially responsible party's number of household dependents?: ________

What is financially responsible party's household 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

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Does patient take any medications? ☐ Yes ☐ No *List all medications:*

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