DC | HEALTH

Universal School-Based Health Center Form
Consent for Health Services and Treatment

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Select School Student Attends:

❑ Anacostia SHS ❑ Ballou SHS ❑ Cardozo EC ❑ Coolidge SHS ❑ Dunbar SHS ❑ Woodson SHS ❑ Roosevelt EC

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____-_____-_____

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address: _____
_____

Will the SBHC be the student's regular doctor? ❑ Yes ❑ No

If no, who is or will be the student's regular doctor?

Name: _____

Telephone: _____

Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____ First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, if applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact information for parent or guardian

Home Tel: _____ Work Tel: _____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid coverage?

❑ No ❑ Yes: Medicaid ID #: _____

Which Plan?

❑ AmeriHealth
❑ Amerigroup
❑ Health Services for Children with Special Health Care Needs (HSCSN)
❑ Trusted Health Plan

Does your child have coverage through your employer or any other type of health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance? ❑ Yes ❑ No

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

❑**YES:** 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 selected School-Based Health Center as long as my child is a student at the school. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.
NOTE: By law, parental consent is not required for the prevention, diagnosis or treatment of a pregnancy or its lawful termination; substance abuse, including drug and alcohol abuse; a mental or emotional health condition or a sexually transmitted disease. Furthermore, parental consent is not required for the application of first aid treatment or the provision of services where the health of a student is endangered. Parental consent is not required for students who are 18 years or older or for legally emancipated students.

❑**NO:** I do not give permission for my child to receive SBHC services.

X _____ _____

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

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.

X _____ _____

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

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT FORM

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SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the licensed health professionals at the School-Based Health Center as part of the school health program approved by the District of Columbia Department of Health (DC Health) and the District of Columbia Public Schools (DC Public Schools.) I understand that the school-based health center will ensure confidentiality in accordance with the law, and that students 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. School health services, including: screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, 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. Reproductive health care services, including abstinence counseling, providing access to birth control, pregnancy testing, STD screening and treatment, HIV testing, PAP smears when indicated, and referrals for abnormal results, as age appropriate.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
8. Dental treatment consisting of examinations, x-rays, diagnosis & treatment modalities that may include cleaning, administration of topical and local anesthesia, fillings and sealants.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of health information obtained by the School Based Health Center to DC Public Schools and DC Health. This information may be protected from disclosure by federal privacy law and District law. I am further authorizing the School-Based Health Center to release specific medical information to DC Public Schools and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, 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, I understand that my revocation does not cover information released prior to the revocation. I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or District privacy laws.

I authorize the School-Based Health Center to release specific medical information of the student named on the reverse page to the DC Public Schools and DC Health.

I understand that the results of reportable diseases and immunizations administered will be released to DC Health and the DC Public Schools. In addition, case records and survey information may be used for program evaluation in accordance with Federal and District laws regarding patient confidentiality.

My signature on page 1 of this form also gives my consent to the School- Based Health Center to contact other providers who have examined my child and to obtain insurance information.

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 school

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT FORM