MONTGOMERY COUNTY SCHOOL HEALTH UNIT CONSENT FOR SERVICES 20____

Student Name: _____ Grade: _____ School: _____

The School Health Unit will provide care for all students. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes. We cannot provide services to your child without this signed consent (except for emergency first aid). Consent can be withdrawn at any time by the parent or guardian.

Please review this form carefully and complete all information that is requested and return to your child's homeroom teacher or directly to the school nurse.

*The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that I will be notified of any abnormal findings.

***All medications sent from home must be accompanied by proper parent/guardian consent and taken to the school nurse immediately upon arrival to school for proper storage and administration. I understand that non-prescription medications can only be given for three days without a physician's order.** I understand that the Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

*In order to ensure my child's safety, school health services may share educationally relevant health information with other school staff having direct involvement with my child. Medication delegation by the school nurse is based on health information on file in the health unit at the time of departure.

*School personnel will make the determination, in case of emergency, to contact 911/EMS for emergency treatment. With all accidents, the student's healthcare coverage must be billed first, as the school's accident insurance is a secondary insurance.

☑ Please review the following list of medications and mark the ones for which you consent:

- ❒ **Acetaminophen** (generic name for **Tylenol®**) **ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**
- ❒ **Ibuprofen** (generic for Motrin®) **ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**
- ❒ **Benadryl®** (generic liquid /capsules/caplets/cream) **ADMINISTERED FOR ALLERGIC REACTIONS**
- ❒ **Anti-diarrheal** (generic for Imodium—7th-12th grades)
- ❒ **Sore Throat Spray** (generic)
- ❒ **Cough Drops** (generic)
- ❒ **Orajel®** (generic oral pain relief)
- ❒ **Vaseline/Lip Lubricant/Carmex/**(generic)
- ❒ **Sterile Eye Drops/Artificial Tears** (generic)
- ❒ **Triple Antibiotic Ointment** (generic)
- ❒ **Antacids** (Chewable—generic)
- ❒ **Anti-Itch/Sting Kill** (generic)
- ❒ **Aloe Vera Gel**
- ❒ **Lemon/Lime Caffeine free Soda**
- ❒ **Peppermint Hard Candy**
- ❒ **Saltine Crackers**

***By signing below, I understand that the above over the counter (OTC) products will be available to be administered by a school nurse in accordance with Montgomery County School Health Protocol, after she/he has evaluated my child's complaint. I give my consent for the child listed above to receive the above checked medications/comfort measures. I understand that medication may be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation.

Known Allergies: _____

Other Medical Conditions: _____

Current Medications: _____

By signing this consent I release Montgomery County Schools from any liability related to the administration of medications or treatment as long as Reasonable and Customary care is provided. This consent is given voluntarily and with full knowledge of its significance.

_____ _____ _____

Parent/Legal Guardian Signature* Relationship to child Date

Health and Emergency Information Form

Students Name: _____ Birth date: _____

Grade_____ School: _____

Street Address _____ Legal Guardian(s): _____

#1 Name_____ Home # (___) _____ Cell # (_____) _____

#1 Name_____ Home # (___) _____ Cell # (_____) _____

Please mark the following CURRENT HEALTH conditions diagnosed by a healthcare provider:

☐**ADD/ADHD** ☐**ANAPHYLAXIS (EPI PEN)** ☐**ASTHMA** ☐**CARDIAC/ HEART CONDITION** ☐**DIABETES**

☐**METABOLIC DISORDER** ☐**MIGRAINES** ☐**SEIZURES OTHER-PLEASE SPECIFY: _____**

List ALL Medication your child takes at school or at home _____

LIST ALL Known Allergies: _____

An individualized health plan (IHP) must be completed for all current health conditions. *A student may not carry a medication (insulin, asthma inhalers, Epi-pens etc) with them UNLESS written permission from their health care provider and parent is provided.

The School Health Unit will provide care for all students. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes and referrals for further medical assessment. The school nurse cannot provide services to your child without this signed consent (except for emergency first aid). The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that I will be notified of any abnormal findings.

All medications sent from home must be in the original container, accompanied by proper parent/guardian consent and must be given to the nurse, the staff member designated to provide health services or the supervising teacher/sponsor/coach for proper storage. (Includes field trips) Prescription meds must have written authorization of prescribing healthcare provider and OTC medications must have written approval of parent/guardian. Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read.

In order to ensure my child's safety, school health services may share educationally relevant health information with others having direct involvement with my child. Medication may be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation; based on health information on file in the health unit at the time of departure. By signing below, I give my child consent to participate in **EDUCATIONAL/SPORTS/CLUB** school-related student trip(s).

I understand that I am responsible to provide all medications and treatment supplies related to my child's health conditions indicated above. I authorize trained school personnel to assist my child with his/her medication as my child's healthcare provider or I have directed if needed. **Teachers/Sponsors are responsible to provide specific information and have specific consent for each trip. Form 09.36 AP.211 is required for any overnight or out of state travel. S**chool personnel will make the determination, in the event of accident or sudden illness while at school or on a school-sponsored trip, to have EMS transport my child to the nearest hospital and authorize treatment as deemed necessary for the health of said child.

EMERGENCY CONTACTS: Please name two (2) persons other than the legal guardian that may take responsibility for your child or make decisions for health care:

1) _____ Phone #_____
2) _____ Phone #_____

Child's Healthcare Provider: _____ Child's Insurance Coverage & Policy Number: _____

The following comfort measures are available as needed while at school: Antacid, Benadryl (allergic reaction), Cough Drop, Peppermint Candy, Saltine Cracker, Lemon/Lime caffeine free Soda, Anti-itch Cream/Spray, Sore Throat Spray, Orajel, Artificial Tears/Eye Wash, Triple Antibiotic Ointment, Vaseline or Lip Lubricant or Aloe Vera Gel. Tylenol and Ibuprofen are only administered with a MD/APRN order or specific parent/guardian consent.

IF YOU DO NOT WANT YOUR CHILD TO HAVE AN ABOVE COMFORT MEASURE PLEASE LIST HERE: ____

_____ _____

Parent/Legal Guardian Signature ***Date***

Review/Revised:4/25/2017

School Year 2018-2019

School Based Health Consent for Services Sterling Health Solutions, Inc.

The Medical Providers (Sterling Health Solutions, Inc.) will offer health services that include, but are not limited to acute care, preventive services, school physicals, medications for minor illnesses and emergency treatment as needed. Basic laboratory tests will be provided at the School Based Clinic when requested by a parent or if a child comes to the clinic with symptoms indicating the need for a lab test, or if it's a required part of the physical exam. Please review this form carefully and complete all information that is requested. **The Providers cannot/will not provide service to your child without this signed consent.** This consent does not cover Immunizations. You must contact the School Based Clinic, or the Providers will contact you for a separate consent for that service. The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing.

Student's School:_____

Last Name: _____ **First Name**:_____ **Middle Name:** _____

Gender: M/F **SSN:**_____ **Birth Date:**_____ **Nickname:**_____

Race: □White □Black/African American □Asian □American Indian/Alaskan Native □Native Hawaiian □ Other

Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino **Primary Language:**_____

Address:_____ **Zip Code**:_____

Contact Phone: _____ **Work Phone:** _____ **Email Address:** _____
Preferred Communication: Phone/Email

In case of emergency, please contact:
Name of Mother/Legal Guardian:_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

Name of Father/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:**_____

Student's doctor: _____ **Student's** dentist: _____ Pharmacy:_____

INSURANCE INFORMATION:
Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____ **ID#**_____ **GROUP#**_____
Subscriber Name:_____ **Subscriber Date of Birth**_____
Subscriber Gender: □Female □Male **Subscriber Phone**_____
Subscriber Address if different from Patient:_____

This information is **required** for the student's health record to be complete but will ONLY be billed if services are provided the by Nurse Practitioner. School nurse visits are not billed to insurance.

Student's Medical History:
The following information will aid the School Nurse/Nurse Practitioner in making an accurate assessment of your child in case of illness or emergency.

ALLERGIES: Please list all medications, vaccines, food or any other allergies

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

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

Any Hospitalizations? □Yes □No

Reason for Hospitalization	Date of Hospitalization	Facility Where Hospitalized

Any Surgeries? □Yes □No

Type of Surgery	Date of Procedure	Facility Where Procedure Was Performed

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Allergies			Heart Murmur			Chicken Pox		
Asthma			Wheezing			Urinary Tract Infection		
Eczema			Pneumonia			Acne		
Seizures			Ear Infections			Serious Injury or Concussion		
Developmental and/or Speech Problems						ADHD/ADD		

FAMILY HISTORY: Do any family members have any of the following conditions?

Condition	Relative	Condition	Relative	Condition	Relative
Heart Attack	Age:	Pancreatic Cancer		Migraine	
High Blood Pressure		Any other Cancer		Seizures	
Congestive Heart Failure		Colitis		Diabetes	
Rheumatic Heart Disease		Crohn's Disease		Goiter	
Congenital Heart Disease		Colon Polyps		Bleeding Tendency	
Breast Cancer	Age:	Hepatitis		Suicide	
Colon Cancer	Age:	Stomach Ulcer		Mental Illness	
Leukemia		Kidney Disease		Tuberculosis	
Melanoma (skin cancer)		Stroke		Other	
Ovarian Cancer		Asthma		Drug or Alcohol Abuse	

When was the last time your child was seen by a doctor?
Doctor's Name: _____ **Reason:** _____ **Date:** _____

Immunization Status: Is your child up to date on immunizations? □Yes □No
Where is the child's immunization record on file: _____
□Yes, I give permission for school nurse to provide a copy of immunization record

Other:
Do you have concerns about your child's health? □Yes □No
Does your child drink alcohol? □Yes □No
Does your child smoke and/or use tobacco products? □Yes □No
Is your child exposed to second hand smoke? □Yes □No

INCOME: ***Note: Sterling Health Solutions, Inc. Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Family Size	Annual Income (*please circle one*)			
1	Below $11,770	$11,771-17,655	$17,656-23,540	Above $23,540
2	Below $15,930	$15,931-23,895	$23,896-31,860	Above $31,860
3	Below $20.090	$20,091-30,135	$30,136-40,180	Above $40,180
4	Below $24,250	$24,251-36,375	$36,376-48,500	Above $48,500
5	Below $28,410	$28,411-42,615	$42,616-56,820	Above $56,820
6	Below $32,570	$32,571-48,855	$48,856-65-140	Above $65,140

Sterling Health Solutions, Inc. Center School Based Health Assignment of Benefits / Consent for Treatment

I consent to the customary tests, procedures that may be deemed necessary for treatment of my child's condition by members of the Medical Staff of Sterling Health Solutions, Inc. Center. Consent is hereby given for such visits to the school nursing office for the purposes of examination, treatment, and procedures rendered by a qualified Nurse Practitioner. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the supplier for services provided by Sterling Health Solutions, Inc. Center. I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. *Services performed by the school nurse are not billed.

Authorize for Release of Medical Information

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, as well as release of records to my child's primary care provider. Further, I release Sterling Health Solutions, Inc. Center and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

Date _____ Signature of the Parent/Legal Guardian _____

Best **phone number** to reach you _____ **Email** to link you to Patient Portal for child's health record _____

Date _____ Signature of Witness _____

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

Date _____ Phone Number _____ Witness Name _____ Address _____

Date _____ Phone Number _____ Witness Name _____ Address _____

CONSENT FOR WELL - CHILD EXAMS

As part of overall health care for children, the school requires Kindergarten and 6th Grade Well Child Exams and it is recommended that all children have a Well Child Exam on a yearly basis. The Nurse Practitioner can complete the exam if you want to get your child's check-up through the school clinic. **All you need to do is sign below giving permission if you would like us to complete your child's Well Child Exam or School Grade Entry Exam.**

If your child has already had a well-child exam or the required school check-up at their primary care physician's office, please forward a copy of it to the school as soon as possible. Well Child exams are billable and will be billed to your insurance/medical card. Although, for private insurance NO COPAY will be billed to you because the children's well-child exams are covered 100% by insurance. So it will be NO COST to you.

All exams can be completed at the school clinic EXCEPT for any required immunizations (shots) because we are not able to bring the vaccines to school. **If your child needs a physical that requires vaccination,** the school nurse will help you schedule an appointment with your child's physician or the health department.

____**Yes**, I would like for Sterling Health Solutions, Inc. to complete my child's exam at school.

____My child has already had their required school exam or the well-child exam.

Parent/Guardian Signature: _____

Best Phone Number to reach you: _____

Date: _____