



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 The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing.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 smoke and/or use tobacco products? Yes No

Does your child drink alcohol? 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: _____