# MONTGOMERY COUNTY SCHOOLS

## Student Registration Form

Date______________________________ Grade________________________________

School______________________________ Homeroom Teacher___________________

**PERSONAL INFORMATION**

**Student's Legal Name**: ________________________________ / ______ / ______ ________________

(Last) (First) (Middle)

______________________________ SS# (optional)

**Residence Address:** ____________________________________________________________

(Street) (Apt. #) (City) (Zip Code)

**Mailing Address** (if different from residence):______________________________________________

(Include P.O. Box # if applicable)

**Home Phone:** ____________________ **Birth Date:** __________________ **Age:** ____________ **Sex:** ☐ M ☐ F

**Ethnicity:** *Select one* ☐ Hispanic ☐ Non-Hispanic

**Race:** *Select all that apply* ☐ Caucasian/White ☐ African American/Black ☐ Asian

☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

**Last School Attended:** ___________________________________ **City/ State:** ______________________________________

Has your child been diagnosed with a disability or special need? ___Y ___N - If yes please provide name of diagnosis, date, where diagnosed, and any additional information helpful for your child ________________________________________

__________________________________________________________________________________________

__________________________________________________________ ____________________

**Person Completing this form – Must be parent or legal guardian (*please print*)** **Date Completed**

**FAMILY INFORMATION: PLEASE PROVIDE THE FOLLOWING INFORMATION:**

**Student Lives With**: (check all that apply)

☐ Mother/Father ☐ Mother ☐ Father ☐ Grandparents ☐ Guardian

☐ Foster Parents ☐ Stepfather/Mother ☐ Stepmother/Father ☐ Other

| Biological/Adoptive Parent Information: | Biological/Adoptive Parent Information: | Legal Guardian (if not biological/adoptive parent) |
|---|---|---|
| Name:____________________________ | Name:____________________________ | Name:____________________________ |
| Address:__________________________ | Address:__________________________ | Address:__________________________ |
| ________________________________ | ________________________________ | ________________________________ |
| Cell Phone:_______________________ | Cell Phone:_______________________ | Cell Phone:_______________________ |
| Work Place:______________________ | Work Place:______________________ | Work Place:______________________ |
| Work Phone:______________________ | Work Phone:______________________ | Work Phone:______________________ |
| Email:___________________________ | Email:___________________________ | Email:___________________________ |
| Step parent (if applicable):________ | Step parent (if applicable):________ | Step parent (if applicable):________ |
| ________________________________ | ________________________________ | ________________________________ |

**It is the responsibility of the parent or guardian to inform the school as changes occur to information on this document.**

VERY IMPORTANT - Please List ALL children living in the household- use separate sheet to list additional children if needed

| Name | Birthdate | School Attending ( if applicable) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

REQUIRED CONTACT INFORMATION – List at least two contacts (OTHER THAN PARENTS) who may pick up your child in the event you cannot be reached:

Name:________________________ Phone:____________ Alt. Phone: ____________

Name:________________________ Phone:____________ Alt. Phone: ____________

Name:________________________ Phone:____________ Alt. Phone: ____________

Name:________________________ Phone:____________ Alt. Phone: ____________

Pick up restrictions: (Note: If biological parent(s) is restricted, court documentation is required to be on file at the school.)____________________________

## BUS RIDER INFORMATION

**In general as a matter of routine:**

I ride the bus twice daily ___Yes ___No

I ride the bus once daily ___Yes ___No

I do not ride the bus ___Yes ___No

If known:

Bus number that picks you up__________ Bus number that drops you off__________

## STUDENT RESIDENCY STATEMENT

This form is intended to address the requirements of the McKinney-Vento Act (Title X, Part C of the No Child Left Behind Act). The questions below are to assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Vento Act. **Information provided on this form is confidential.**

Where does the student stay at night:

- ☐ In a shelter (family shelter, domestic violence shelter, or transitional living program);
- ☐ In a motel, hotel, or weekly-rate housing;
- ☐ In a house with parent(s);
- ☐ In a house or apartment with more than one family because of economic hardship or loss;
- ☐ In an abandoned building, a car, at a campground, or on the street;
- ☐ In a temporary foster care or with an adult who is not the parent or legal guardian;
- ☐ In substandard housing (no electricity, no water, and/or no heat);
- ☐ With friends or family because student is a runaway or unaccompanied youth; or
- ☐ Other ( please specify):______________________________

I certify the above named student qualifies for the child Nutrition Program under the provisions of the McKinney-Vento Act.

Date: ____________ McKinney-Vento Liaison Signature: ______________________________

**It is the responsibility of the parent or guardian to inform the school as changes occur to information on this document.**

# HOME LANGUAGE SURVEY

Student Name: _______________ Birth Date: _______________ Sex: ❑ Male ❑ Female

Parent/Guardian Name: _______________

Address: _______________

Home Telephone: _______________ Work Telephone: _______________

School: _______________ Grade: _______________ Date: _______________

1. Was your child born in the United States? ❑ Yes ❑ No
   If yes, in which state? _______________
   If no, in what other country? _______________

2. Has your child attended any school in the United States for any three years during their lifetime? ❑ Yes ❑ No
   If yes, please provide school name(s), state, and dates attended:
   Name of School _______________ State ________ Dates Attended _______________
   Name of School _______________ State ________ Dates Attended _______________
   Name of School _______________ State ________ Dates Attended _______________

3. What language is spoken by you and your family most of the time at home? _______________

4. If available, in what language would you prefer to receive communication from the school? _______________

5. Please check if your child is:
   A. ❑ Native American Indian
   B. ❑ Alaska Native
   C. ❑ Native Pacific Islander
   D. ❑ Native U.S. Virgin Islander

6. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

**If you responded "Yes" to question number 6 above, please answer the following questions:**

7. What language did your child learn when he/she first began to talk? _______________

8. What language does your child most frequently speak at home? _______________

9. What language do you most frequently speak to your child? (Father) _______________
   (Mother) _______________

10. Please describe the language understood by your child. (Check only one)
    A. ❑ Understands only the home language and no English.
    B. ❑ Understands mostly the home language and some English.
    C. ❑ Understands the home language and English equally.
    D. ❑ Understands mostly English and some of the home language.
    E. ❑ Understands only English.

_______________ Parent or Guardian's Signature

_______________ Date

| OFFICE USE ONLY | | | |
|---|---|---|---|
| Student ID # | Date Distributed | Date Received | |
| | | | |



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# Publication Consent Form

**School** ______________________________________________

**PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL.**

Dear Parent/Guardian:

At some time during the school year, school/District personnel or other District-authorized persons may videotape or photograph classroom activities or special projects in which your child participates during or after the school day for public awareness or fund-raising purposes. On special occasions such as a videotape or photograph of a class or school play or of an academic or athletic event, the film or photograph may be viewed by a general audience including, but not limited to, publishing pictures in yearbooks, event programs and newsletters, or posting a likeness of your child on the school or District Web site.

Under 09.14 AP.12, the District has designated student photographs as “directory information.” Consistent with that annual notice, a photograph of an individual student may be released to others and/or reproduced in school yearbooks as long as the parent or adult student has not submitted written notice (by returning form 09.14 AP.12) indicating that they do not wish photographs of the student to be released.

This form covers permission for the District to record and use the recorded image, voice, or work of the student (photographed, filmed, taped, or digitally recorded) for public awareness purposes, including publication on the school and/or District’s web site and in school yearbooks.

Please review this form carefully, sign and date the form, and submit the form to the school.

Once signed and dated, this form shall remain in effect for your child’s enrollment in any of our District schools. However, at any time during the school year, you may amend this form only for future uses/preferences by notifying the Principal in writing of your request.

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*As the parent(s)/guardians(s) of* ______________________________*, I/we give the*

***Student’s Name*** (**PLEASE PRINT**)

*Montgomery County School District permission to release my/our child’s name, photograph, and/or audio/video reproduction for publication to the general public concerning school functions and activities, including academic and athletic activities.*

Name of Parent(s)/Guardian(s) (**PLEASE PRINT**) ______________________________

______________________________ ______________

***Parent/Guardian’s Signature*** ***Date***

NOTE: If the recorded image, voice, or work of a student is to be included in a publication as part of a commercial or for-profit fund-raising endeavor, affirmative authorization of the parent/guardian or eligible student must be obtained.

Review/Revised:7/26/2016

# Electronic Access/User Agreement Forms

## AUP FORM FOR STUDENTS

**STUDENT'S NAME (LAST)** ___________________ **(FIRST)** ___________________ **(INITIAL)** _____

**STUDENT'S ADDRESS** ________________________________________________________________

**STUDENT'S AGE** ____ **DATE OF BIRTH** __________ **SEX** ___ **PHONE NUMBER** _____________

**SCHOOL** __________________________________________________________________________

**GRADE** _______ **HOMEROOM/CLASSROOM** _______________________

As a user of the **Montgomery County School District's** computer network, I hereby agree to comply with the District's Internet and electronic mail rules and to communicate over the network in a responsible manner while abiding by all relevant laws and restrictions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation, my access privileges may be revoked and school disciplinary action and/or legal action may be taken.

Student's Signature ____________________________________________ Date _________________

**Prior to the student's being granted independent access privileges, the following section must be completed for students under 18 years of age:**

As the parent or legal guardian of the student (under 18) signing above, I grant permission for my child to access networked computer services such as electronic mail and the Internet. I understand that this access is designed for educational purposes; however, I also recognize that some materials on the Internet may be objectionable, and I accept responsibility for guidance of Internet use by setting and conveying standards for my child to follow when selecting, sharing, researching, or exploring electronic information and media.

**CONSENT FOR USE**

By signing this form, you hereby accept and agree that your child's rights to use the electronic resources provided by the District and/or the Kentucky Department of Education (KDE) are subject to the terms and conditions set forth in District policy/procedure. Please also be advised that data stored in relation to such services is managed by the District pursuant to policy 08.2323 and accompanying procedures. You also understand that the e-mail address provided to your child can also be used to access other electronic services or technologies that may or may not be sponsored by the District, which provide features such as online storage, online communications and collaborations, and instant messaging. Use of those services is subject to either standard consumer terms of use or a standard consent model. Data stored in those systems, where applicable, may be managed pursuant to the agreement between KDE and designated service providers or between the end user and the service provider. Before your child can use online services, he/she must accept the service agreement and, in certain cases, obtain your consent.

Name of Parent/Guardian (Please print) __________________________________________________

Signature of Parent/Guardian ____________________________________________________________

**STUDENTS**: Return this form to your school.

## MONTGOMERY COUNTY SCHOOL HEALTH UNIT CONSENT FOR SERVICES 2018-19

**Student Name:** ________________________________________ **Grade:** _____ **School:** ___________________

The School Health Unit will provide care for all students P-12. 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. However, 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 legal guardians are 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 consecutively 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. **I understand that in order to ensure my child's safety, school health services may share educationally relevant health information with school staff or medical professionals having direct involvement with my child, or may contact the healthcare provider for necessary health information or medication and treatment clarification.**

### Please CHECK MARK ☑ the following items for which you consent:

❒ **Acetaminophen** (generic name for **Tylenol®**)—**GIVEN ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**

❒ **Ibuprofen** (generic for Motrin®) --**GIVEN ONLY WITH SPECIFIC PARENT CONSENT OR PERSONAL SUPPLY**

❒ **Antacids** (generic)–AS AGE APPROPRIATE

❒ **Cough Drops** (generic) –AS AGE APPROPRIATE

❒ **Peppermint Hard/Soft Candy –**AS AGE APPROPRIATE

❒ **Benadryl®** (generic)-AS AGE APPROPRIATE

❒ **Sore Throat Spray** (generic)—AS AGE APPROPRIATE

❒ **Anti-diarrheal** (generic for Imodium—7th-12th grades)

❒ **Sterile Eye Drops/Artificial Tears** (generic)

❒ **Saltine Crackers**

❒ **Lemon/Lime Caffeine free Soda**

❒ **Aloe Vera Gel**

❒ **Orajel®** (generic oral pain relief)

❒ **Anti-Itch/Sting Kill** (generic)

❒ **Triple Antibiotic Ointment** (generic)

❒ **Vaseline/Lip Lubricant/Carmex** (generic)

By signing below, **I understand** that the above over the counter (OTC) products may 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 as indicated above. **I understand** that medications will be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation. **I understand** that 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.

**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: ______________________________________