Health Care Integrated Services
School Parental Consent Form (Grades PK-12)
Admission and Termination

_____ *(School(s) Covered)*
_____ *(HCIS)*
_____ *(HCIS Address)*

Office Use Only

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:_____
_____
_____ _____ _____
City State Zip Code

Who is 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?
❑ No ❑ Yes: Medicaid ID # _____

Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # _____

Which Plan?
❑ LA Care ❑ Anthem
❑ HealthNet ❑ Blue Cross / Blue Shield
❑ Care 1st ❑ Kaiser

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 an In-Person Assistor authorized by the CA State of Health Marketplace to contact you to enroll into health insurance?
❑ No ❑ Yes What is the best time to contact you?

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

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 _____(HCIS) School-Based Health Center.
NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

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

HIPAA COMPLIANT 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 _____ _____

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

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

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SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of _____ _____(HCIS) as part of the school health program approved by California Department of Public Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils 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. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, 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. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. Annual health questionnaire/survey.

CALIFORNIA DEPARTMENT OF EDUCATION'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Board of Education either because it is required by law, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Failure to provide immunization may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, 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, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the _____(HCIS) School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education.

I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information Required by Law:
- New Entrantce Exam (Form 211S)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment
- Conditions which limit a student's daily activity
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Health insurance coverage
- Enrollment in School-Based Health Center
- Individualized Education Program (IEP)

My signature on page 1 of this form also gives my consent to _____(HCIS) to contact other providers that 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 SBHC

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT