SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

The Cleveland Heights-University Heights City School District is partnering with The MetroHealth System to provide school-based supplemental health services to our students. Completion of this consent for treatment form (the "Consent Form") is required for your child to receive supplemental health services.

School nursing and emergency services will still be provided to students as always, whether or not you choose to take part in this added service.

Student/Patient Information		
Student Last Name: Student First Name:		
Date of Birth:	Sex (please circle): Female ◉ Male ○	Social Security #:
Home Address:		City:
State: Zip Code:		Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic (please circle)? Yes ◉ No ○	
Race (please circle): American Indian/Alaskan Native☐ Asian☐ Native American/Pacific Islander☐ Caucasian☐ African American☐ Declined☐ Other:		
Name of Primary Care Provider/Physician (PCP):		
PCP Location (please circle): - Cleveland Clinic☐ MetroHealth☐ UH/Rainbow Babies and Children☐ Other:		
Legal Guardian Information		
Guardian's Last Name: Guardian's First Name:		
Date of Birth:		Social Security #:
Home Phone:		Cell Phone:
Employer:		Employer Phone:
Student/Patient Insurance Information		
Child/Teen has insurance (please circle): Yes ○ or No ○		
Name of Insurance Company:		Subscriber's Name:
Group Number:		Subscriber ID:
Emergency Contact Information		
Name:		Relationship:
Phone Number:		May we leave a message? Yes ○ No ○

Student Health History (to be completed by parent/legal guardian)

Patient/Student Medical History (please circle all that apply)

Asthma ☐	Cancer/Leukemia ☐	Eczema ☐	Migraines ☐
Premature Birth ☐	Sickle Cell ☐	Spine Disorders ☐	Bladder/Urinary Problems ☐
Seizures ☐	Glasses/Contacts ☐	Hearing Aids ☐	Mental Health Issues ☐
Blood Disorder ☐	Diabetes ☐	Pneumonia ☐	Kidney/Renal Disease ☐
Heart Problem ☐	Development Problems ☐	Bowel Issues/Constipation ☐	Tuberculosis/TB ☐

Other (Please explain):

Patient/Student Current Medications (vitamins, inhalers, prescriptions, other)

Name of Medication	Dose	Amount Taken	Times per Day

Preferred Retail Pharmacy Name:

Address:	Phone Number:

Patient/Student Allergies

□ **YES** – Please list below:	□ **NO KNOWN ALLERGIES**
Food:	
Medications:	
Insects:	
Seasonal:	
Animals:	

Immunization History

Has your child ever had a reaction to any immunizations/shots? Yes ○ No ○
If YES, please explain reaction:
What immunization/shot caused reaction:

Patient Hospital/Surgery History

Past Hospital Stays: Yes ○ No ○	Explain:
Past Surgeries: Yes ○ No ○	Explain:
ER visits in past year: Yes ○ No ○	How many:

Family History (please circle all that apply) and list who has the problem next to it (mom, dad, grandparent, brother, sister)

Anemia ☐		High Blood Pressure ☐	
SIDS/Sudden Infant Death ☐		Asthma ☐	
Headaches ☐		Stroke ☐	
Diabetes ☐		Alcohol / Drug Abuse ☐	
AIDS/HIV ☐		Cancer ☐	
Arthritis ☐		High Cholesterol ☐	
Heart Disease ☐		Seizures ☐	
Sickle Cell ☐		Tuberculosis/TB ☐	
Mental Health Issues ☐		Other (please list)	

School-Based Supplemental Health Services Consent Form

The purpose of this Consent Form is to allow parents/custodians/emancipated minors/students over the age of 18 to:

(1) give informed consent for your child to participate in and receive treatment from a MetroHealth physician or healthcare provider through its School Health Program;
(2) acknowledge responsibility for the payment of charges and fees not covered by insurance; and
(3) give permission to release your child's protected health information ("PHI") from The MetroHealth System (MetroHealth) to the Cleveland Heights-University Heights City School District Medical Staff.

Consent for Health Services/Treatment

By signing below, the Parent/Guardian consents for your Child to receive necessary and/or advisable medical treatment from a MetroHealth physician or healthcare provider through MetroHealth's School Health Program. Such medical treatment may include, but is not limited to items listed below. The Parent/Guardian understands that they have the opportunity to ask and have any questions answered about the risks, benefits, and alternatives of the Services by contacting MetroHealth at (216) 957-1303 and that MetroHealth reommends the Parent/Guardian do so prior to signing this Consent Form if they have any questions about the Services. The Parent/Guardian consents to let providers participating in School-Based Supplemental Health Services perform **the following** services/treatment for my child:

(Circle any services or immunizations you DO NOT want your child to receive.)

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Routine lab tests
- Prescription medications
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Pregnancy testing, diagnosis and treatment of sexually transmitted infections
- Mental/behavioral health assessment, screening, and counseling
- Vision and hearing screening and follow up services If needed
- Dental screening and services if needed
- Health education and prevention programs
- Sports medicine services

Immunizations (Shots)
Your school nurse and the School Health Program team will review your child's record to determine which shots are needed.

School Required Immunizations:

· DTap/Td · Tdap · Polio · Hepatitis B
· MMR (Measles, Mumps, Rubella) · Meningococcal A
· Varicella (Chicken Pox)

Pediatric/Adolescent Recommended Immunizations:

· Human Papillomavirus (HPV) · Influenza (Flu)
· Hepatitis A · Meningococcal B

Please visit **http://www.immunize.org/vis/** to find the Vaccine Information Statement for each vaccine, which will explain risks and benefits of all vaccines.

Agreement of Financial Responsibility

If applicable, MetroHealth will bill your Child's insurance carrier(s) for charges and fees covered by your Child's insurance plan. Parent/Guardian agrees to provide complete, accurate and timely information relating to any available health insurance in order for MetroHealth to seek payment in a timely manner. Parent/Guardian understands that a failure to provide complete, accurate and timely information, including any changes in insurance coverage, may prevent the provider from complying with the administrative rules of your Child's insurance plan. Parent/Guardian may obtain a list of usual and customary charges from MetroHealth upon request.

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS CONSENT FORM AND THAT I HAVE RECEIVED INFORMATION ON THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, INCLUDING THE PROCESS FOR FILING A COMPLAINT OR GRIEVANCE.

Signature of Parent/Legal Guardian: _____

[1]Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.

[CONTINUE TO BACK PAGE – ANOTHER SIGNATURE NEEDED]

Release of PHI

I authorize MetroHealth to provide my Child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to Cleveland Heights-University Heights School Nurses for treatment, referral and/or care coordination. To help coordinate care, MetroHealth may receive and copy medical information within Child's school records via assistance from Cleveland Heights-University Heights School Nurses and other staff involved in the administration and operation of its health program.

This permission will expire when your Child is no longer an enrolled student in the Cleveland Heights-University Heights City School District or when it is terminated in writing.

I understand that my express consent may be required for the disclosure of information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If your Child has been tested, treated, or diagnosed with any such injury, disease, or illness, MetroHealth is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For records related to alcohol and drug treatment, federal law prohibits recipient from making further disclosure of this information unless the additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal law.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my Child's PHI, it will not in any way prevent Participant from receiving care or treatment from MetroHealth. I understand that I may terminate this authorization in writing at any time, prior to the release of my Child's PHI.

Notice of Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices if my child is a new patient at The MetroHealth System. I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for The MetroHealth System at the Cleveland Heights High School Health Program site if my child has been a patient at The MetroHealth System. I know that I can also view them online:

https://www.metrohealth.org/patients-and-visitors

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS CONSENT TO RELEASE PHI AND CONSENT TO THE RELEASE OF MY CHILD'S PHI TO CLEVELAND HEIGHTS – UNIVERSITY HEIGHTS SCHOOL DISTRICT SCHOOL NURSES.

I, PARENT/GUARDIAN, ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS CONSENT.

THIS CONSENT FORM WILL REMAIN VALID WHILE PARTICIPANT IS ENROLLED IN THE CLEVELAND HEIGHTS – UNIVERSITY HEIGHTS SCHOOL DISTRICT UNTIL TERMINATED IN WRITING.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____

Date: _____

Student Name:	**Student DOB:**	**Student School:**

[1]Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.