Name_____ DOB_____Grade_____CLAY COUNTY

School Based Health Consent for Services
Family Practice of Kentucky

Please read carefully: In order for us to see your child in school based clinics, all pages of this form must be completed by the child's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their teacher or nurses' station. Consent is for the 2022-23 school year and may be withdrawn at any time.

Child's School:_____

_____ _____ _____
Student's Last Name First Name/ Middle Initial Date of Birth

Social Security Number: _____ Gender: ___Male ___Female

Race: ___American Indian or Alaska Native ___Asian ___Black or African American
___ Native Hawaiian or Other Pacific Islander ___White

Homeless?___ Yes ___No Public Housing? ___Yes ___No Migrant Worker? ___Yes ___No
Foster Child ___Yes ____ No

Ethnicity: Are you Hispanic or Latino? ___Yes ___No

Primary Language: _____ Religion Preference: (optional) _____

Address: _____

City _____ State _____ Zip Code _____

Physical Address (If Mailing Address is a P.O. Box):
_____

Home / Cell Phone Number: _____

In Case of Emergency Please Contact:

Name of Mother/ Legal Guardian_____

Mother's Social Security Number:_____ Mother's Date of Birth: _____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

Name_____ DOB_____Grade_____CLAY COUNTY

Name of Father/ Legal Guardian: _____

Father's Social Security Number:_____ Father's Date of Birth: _____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

If Immediate Family is Not Available, Please Contact:

Name and Relationship to Child: _____

_____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number

Student's Medical History

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

___ Measles
___ Mumps
___ Anemia
___ Birth Defects
___ Diabetes
___ Chicken Pox
___ Rheumatic Fever
___ Asthma
___ Sleep Problems
___ Scarlet Fever
___ Seizures
___ Unexplained Weight Loss
___ Unexplained Tiredness
___ Persistent Cough
___ Unexplained Weight Gain
___ Leukemia
___Stomach or Bowel Problems
___ Joint or Muscle Pain or Stiffness
___ Exposed to Tuberculosis
___ Shortness of Breath
___ Head, Eyes, Ears, Throat Problems
___ Blood Transfusions
___ Anaphylactic Episodes
___ Chest Pain

If you answered yes to any of the above, please explain: _____
_____

Student's Medications taken on a regular basis: _____

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

Student's doctor: _____ Address: _____

Student's dentist: _____ Address: _____

Student's Pharmacy: _____ Address: _____

Name_____ DOB_____Grade_____CLAY COUNTY

___ Any Operations (reason/date):_____

___ Any Hospitalizations (reason / date): _____

___ Any serious injuries or illnesses (describe): _____

When was the last time your child was seen by a doctor?

_____

Doctor's Name Reason Date

Student's allergy to FOOD, MEDICATIONS, OR ENVIRONMENTAL POLLENS? Yes No
IF YES, PLEASE LIST: _____

Have there been any recent upsets in the family that might affect your child? ___Yes ___No
If you answered yes please explain: _____

Family Medical History:

Please check the appropriate space if any of the child's blood relatives(mother, father, brother, sister) has any of the following conditions.

_____HIV/AIDS	_____ COPD/Emphysema/Bronchitis	_____ Liver Disease/Hepatitis
_____Alcohol/Drug Addiction	_____ Diabetes	_____Mental Illness
___ __Alzhemier's	_____Epilepsy/Seizures	_____Osteoporosis
___ __Arthritis	_____ Heart Attack/Stroke	_____Sickle Cell
_____ Asthma	_____ High Blood Pressure	_____ Thyroid Disorder
_____ Birth Defects	_____ High Cholesterol	_____Tuberculosis/TB
_____ Bleeding Disorders	_____ Kidney Disease	_____Other:
_____ Cancer		

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 request a copy of immunization record

Would you be interested in your child receiving vaccinations at school? ____YES ___NO

COVID AND/OR FLU/STREP TESTING CONSENT_____ YES. _____NO

Other:

Do you have concerns about your child's health? ___Yes ___No

Is your child exposed to second hand smoke? ___Yes ___No

Does your child smoke and/or use tobacco products? ___Yes ___No

Name_____ DOB_____Grade_____CLAY COUNTY

Does your child drink alcohol? ___Yes ___No

The following list of medications will be on hand at the Satellite School Clinic to be administered by the School Nurse after she has evaluated your child's complaint.

Acetaminophen (Generic name for Tylenol)	Ibuprofen (Generic name for Advil)
Claritin for allergies	Orajel/ Orasol
Refresh Plus Eye Drops/ Refresh	Zofran for nausea
Tums for indigestion	Triple antibiotic ointment
Diphenhydramine (Generic for Benadryl)	Hydrocortisone 1% Cream
Tussin DM	Hydrogen Peroxide (for wound cleansing)
Solarcaine spray for burns and scrapes	Simethicone for gas
Imodium for diarrhea	Other medications not listed may be available

If you prefer we do not administer a drug listed above please list below.

Please complete the following insurance information for your student. This information is **required** for the students health record to be complete

Medical Card/Managed Care Organization (MCOs)
Insurance Company: _____ Policy Number: _____

Health Insurance- Please Fully Complete and Please attach copy of insurance card
Insurance Company: _____ Policy Number: _____
Group Number: _____
Send Medical Claims to Address on Card: _____
Name on Insurance Card: _____

Policy Holder Information:
Name of Primary Insured (policy holder): _____
Relationship to Patient: _____
Social Security Number of Primary Insured (policy holder): _____
Gender: _____ Policy Holder's Date of Birth:_____
Mailing Address: _____

Family Practice of Kentucky School Based Health

Assignment of Benefits / Consent for Treatment

I consent to the customary tests (for example blood glucose testing), procedures that may be deemed necessary for treatment of my child's condition by Nurses, Family Nurse Practitioners and Physicians. members of the Medical Staff and Employees of Family Practice of Kentucky. Consent is hereby given for such visits to the school nurse, examination, treatment, and procedures.

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 Family Practice of Kentucky

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.

Authorize for Release of Medical Information for Billing Purpose Only

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. Further, I release Family Practice of Kentucky and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to indemnify 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 the 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 of the exam can be completed at the school clinic including any required immunizations (shots) if they are available at the time of the exam. **If the required immunizations are not available at the time of exam,** the school nurse will help you schedule an appointment with your child's physician or the health department.

____**Yes**, I would like for Family Practice of Kentucky to complete my child's exam at school.

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

____I give my permission for Family Practice of Kentucky to request a copy of the well-child exam from _____ (Location of Exam)

Parent/Guardian Signature:_____

Best Phone Number to reach you: _____

Family Practice of Kentucky /Kentucky TeleHealth Network

TELEMEDICINE INFORMED CONSENT FORM

PATIENT INFORMATION

Patient Name:	**DOB:**
Site Where Patient is Seen via Telehealth: Clay County Schools	
Consulting Provider Name Seeing Patient via Telehealth:	**Provider Location:**

INTRODUCTION

Your child is going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

Your child will be introduced to the provider and anyone else who is in the room with the provider. Your child may ask questions of the provider or any telemedicine staff in the room with you, if they are unsure of what is happening. If your child is not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my child's care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to the _____ for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my child's care.

I hereby authorize _____Family Practice of Kentucky_____ to use telemedicine in the course of my child's diagnosis and treatment.
(Agency or Physician Name)

Signature of Patient (or authorized person) _____ Date/Time _____

If authorized signer, relationship to patient _____

Witness _____ Date/Time _____

Kentucky Telehealth Board – Sept 2016