Walk-in Care FOR SCHOOLS

CONSENT FOR SERVICES 2022-2023 SCHOOL YEAR

KING'S DAUGHTERS

INITIAL OFFERING OF SERVICES

❑ Yes. I would like my child to access these services. I have completed all the information.
❑ No, I do not want my child to access these services.

Please read carefully: In order for King's Daughters ("KDMC", "we" or "us") to see a student at the school listed below, all pages of this form must be completed by the student's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their homeroom teacher or other appropriate school representative. Consent is for the 2022-2023 school year and may be withdrawn at any time in writing by the signatory below.

1. STUDENT INFORMATION

Today's date: / /

School district: School name:

Student name: Gender: ❑ Male ❑ Female Date of birth: / /

Address:

City: State: Zip code:

Home telephone: Mobile telephone:

2. EMERGENCY CONTACT INFORMATION

Mother or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

Father or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

If parents or legal guardians are not available, please contact:
Name and relationship to student:

Home telephone: Mobile telephone:

Work telephone: Email address:

3. STUDENT'S MEDICAL HISTORY

This information will aid in making an accurate assessment in case of illness or emergency. Please check if the student has ever had the following:

❑ Anaphylatic episodes
❑ Anemia
❑ Asthma
❑ Birth defects
❑ Blood transfusions
❑ Chest pain
❑ Chicken pox
❑ Cough-persistent
❑ Diabetes
❑ Fatigue-unexplained
❑ Head/eyes/ears/throat problems
❑ Joint/muscle pain/ stiffness
❑ Leukemia
❑ Measles
❑ Mumps
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Shortness of breath
❑ Sleep problems
❑ Stomach/bowel problems
❑ Tuberculosis exposure
❑ Weight gain-unexplained
❑ Weight loss-unexplained

Please explain any checked items:

Medications take by the student on a regular basis:

Does the student have allergies to food, medications or environmental pollens?....❑ Yes ❑ No

If yes, please list:

Student's medical provider: Telephone:

Student's pharmacy: Telephone:

4. INSURANCE INFORMATION

Please complete the following insurance information for student. This information is required for student's health record to be complete but will only be billed if services are provided by King's Daughters. School nurse visits are not billed to insurance. **Please fully complete and attach copy of insurance card.**

PRIMARY POLICY

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of primary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of primary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

SECONDARY POLICY

Do you have another health insurance policy that may provide additional coverage?..... ❑ Yes ❑ No If yes, please provide information below.

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of secondary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of secondary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

5. CONSENT AND PERMISSION

By my signature below, I hereby give consent for student to receive the following services from King's Daughters while at school:

1. Annual well visits
2. Physical/wellness exam
3. Sports physical exam
4. Acute visits
5. Lab draws
6. Point of care testing
7. Flu immunizations (the flu immunization and all other immunizations will require a separate consent)
8. Medication administration
9. Drug dispensing
10. Education
11. Telemedicine
12. COVID-19 testing

Would you liked your child to have their yearly physical (wellness visit) with our provider while at school?.....❑ Yes.....❑ No

Are there services you definitely do not want your student to receive while at school?

Prior to providing any of the services above, KDMC or school will make a courtesy call to you and will accommodate, within reason, your request to be present when services are rendered. However, if we are unable to reach you, we will still provide services to student pursuant to this consent.

In addition, by my signature below, I hereby give permission as follows:

1. To King's Daughters to review student's school record, including attendance and other information, if applicable, that will assist in treating student;
2. On behalf of student to participate in ongoing evaluations administered by King's Daughters, including questionnaires and surveys;
3. To King's Daughters to disclose to appropriate school staff the medical information of student, as King's Daughters deems necessary;
4. To the following hospitals to release to King's Daughters student's emergency room reports: _____
5. To King's Daughters to disclose to any appropriate agencies or medical practitioner any medical and billing information that may result from student's contact with (include clinic name): _____
6. To King's Daughters to obtain any records or information from any agency or private professional regarding student's care.

_____ King's Daughters is released from all liability that may arise from the permissions granted in Section 5.
initial

At the end of this form, please provide an email address for an account that you regularly check. This will enable you to register for MyChart, an online service that will provide you with easy, confidential access to student's medical records.

By my signature below, I agree to provide King's Daughters with updated or additional information applicable to Sections 3 through 6 of this form, as necessary. This includes information related to the medications taken by student and the over-the-counter medications you wish student not to receive.

6. RELEASE OF INFORMATION FOR BILLING PURPOSES

By my signature below, I hereby authorize the release of student's medical information to applicable third-party payors, governmental agencies, and other organizations, as necessary for billing purposes only. 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 student's records. I understand that I have the authority to release the above referenced medical records on behalf of student. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third-party payors pursuant to KRS 214.420.

_____ King's Daughters is released from all liability that may arise from the permissions granted in this Section 6.
initial

7. PRIVACY AND ASSIGNMENT OF BENEFITS

This form has been fully explained to me. I have been given an opportunity to ask questions and am satisfied that I understand its content and significance. By my signature below, I agree that the information I've provided in this form is true and accurate to the best of my knowledge. I understand that King's Daughters shall provide a copy of their Notice of Privacy Practices upon my request, and that said Notice is also available at KingsDaughtersHealth.com. I also request payment of authorized medical insurance benefits be made to King's Daughters on student's behalf for services he/she receives. I realize I am responsible to pay for any non-covered services student receives and/or services requiring insurance authorization.

Date: _____

Signature of the parent/legal guardian: _____

Telephone: _____

Email: _____