STERLING HEALTH CARE

School Year 2023-2024

School Based Health Consent for Services Sterling Health Care, Inc.

The Medical Providers (Sterling Health Care, 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 The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing.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:**_____ **Interpreter Needed?** □Yes □No

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:**_____

Would you like your student's visit note sent to their doctor? □Yes □No

INSURANCE INFORMATION:
Do you have insurance? □Yes □No
Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____ **ID#**_____ **GROUP#**_____
Policy Holder Name:_____ **Policy Holder Date of Birth:**_____
Policy Holder Gender: □Female □Male **Policy Holder Phone:**_____ **Policy Holder SSN:**_____
Policy Holder Address if different from Patient:_____
Birth Mother's Full Name:_____ **DOB:**_____ **SSN:**_____
*Only required if Birth Mother is still on student's insurance.

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 or PA. School nurse visits are not billed to insurance.

Student's Medical History:
The following information will aid the School Nurse/Nurse Practitioner/PA 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		
Diabetes						Other		
If Other Please Explain:								

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 Care, 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!***

Household Size: _____ **Family Income:** _____

Sterling Health Care, 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 Care, 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 or PA. 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 Care, 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 Care, 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 (REQUIRED)

_____ _____

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