



School Based Health Center Consent to Treat

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Name: _____

DOB: _____

MRN: _____

Patient Information	Patient Name: _____ Last First Middle	Gender: ☐ Male ☐ Female ☐ Other
	Address: _____	
	Date of Birth: _____	Phone: () _____ Grade: _____
	Parent/Person Completing Form: _____	
Notice	I understand that Cincinnati Children's Hospital Medical Center operates the school-based health center in my/my child's school. I allow Cincinnati Children's to give care and treatment to me/my child at the school-based health center. I am authorized by law to give consent for my child. This consent is in place until it is removed by me in writing. I have received a copy of Cincinnati Children's Notice of Privacy Practices. Cincinnati Children's may use or share health or personal information about me/my child as stated in the Notice. This consent allows Cincinnati Children's to access and review me/my child's medical record information from previous providers at the Center, including Neighborhood Health Care, Inc. Please apply any insurance benefits to Cincinnati Children's for services performed.	
	Signature of Patient: _____ Date: _____ (if 18 years of age or older OR is an emancipated minor)	
	Signature of ☐ Parent ☐ Person Authorized to Consent (check one): _____ Date: _____	
	_____ By initialing here, I agree that my typed signature is the same as my handwritten signature for this consent. _____ By initialing here, I have gotten the Notice of Privacy Practices.	
Submit	Please make sure that all sections are completed. Then, please return the form to your School-Based Health Center location or email it to SchoolBasedHealthClinics@cchmc.org. Please check your School-Based Health Center location: ☐ Hughes ☐ Rockdale ☐ South Avondale	

Parent/Person Authorized to Consent Name: _____

Relationship to Child: _____ Parent/Person Authorized to Consent Date of Birth: _____

Address: _____

Primary Phone Number: () _____ Additional Phone Number: () _____

Emergency Contact Person Name & Phone: _____

Child's Doctor/Clinic: _____ Child's Dentist: _____

Preferred Pharmacy: _____

What type of insurance do you have for your child? Check all that apply:

Insurance Provider		Insurance Number	
☐	Medicaid	MMIS #	Member #
☐	Healthy Start/Healthy Families (CHIP)		
☐	Private Insurance (List below):		
	1.		
	2.		
	3.		

