IFM Community Medicine School Health Program
Parental Consent Form (Grades PK-12)

St. Louis County Special School District

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address:_____

_____ _____ _____
City State Zip Code

Who is the student's regular doctor?

Name: _____

Telephone: _____

What is your preferred pharmacy?_Name_____

Location including zip code _____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, If Applicable

Last Name: _____First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian

Home Tel: _____Work Tel: _____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION (insurance will be billed but NO OUT OF POCKET EXPENSE to family)

Does your child have Straight Medicaid?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have MoHealthnet?

❑ No ❑ Yes: CHP # _____

Which Plan?

_____

Does your child have other insurance?

❑ No ❑ Yes:

Insurance Company: _____

ID Number: _____

Group Number: _____

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by IFM Community Medicine School-Based Health Center and telemedicine service.
NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention for students over 13 years of age, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT
Valid for 2023-2024 School Year

IFM Community Medicine School Health Program
School Parental Consent Form
St. Louis County Special School District

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of IFM COMMUNITY MEDICINE as part of the school health program approved by the St. Louis County Special School District. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and *required and recommended immunizations.*
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the school-based health center.
8. Vaccines required by the State for school attendance.
9. Telehealth Services

Time Period During Which Healthcare Services are Authorized:
From: Date that form is signed on opposite page
To: One year after

HIPAA Authorization for Use or Sharing of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), your signature may be required in certain circumstances before your health information may be used or shared.

This authorization permits IFM Community Medicine to release certain medical information as stated below. You may refuse to sign this Authorization. You will not be refused health care treatment if you do not sign this Authorization. You may sign this form and later change your mind by sending a letter to the IFM Community Medicine. You can request a copy of this form.

IFM Community Medicine may use or disclose my (my child’s) medical information regarding treatment or payment for services. IFM Community Medicine may share information with insurance companies for payment and your primary care provider (if applicable) and others for treatment.

I understand that IFM Community Medicine will make a good faith effort to release only the minimum amount of necessary information needed to carry this out.

I understand that I have the right to cancel this permission at any time. I understand that I must do so in writing and present my cancelation to the SSD Nursing Services. I understand cancellation will not apply to any previously released information. I understand this consent form is valid until I revoke it.