Goodside Health

Health Services Consent Form

District Name _____ **School Name** _____

Please fill out the consent form below to ensure the patient has access to expanded health services at school.

PATIENT INFORMATION

First Name _____ **Last Name** _____

Patient Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Birth Sex: ☐ Male ☐ Female

PARENT/GUARDIAN AND CONTACT INFORMATION

Relationship to Patient:

☐ Self ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Step-father ☐ Step-mother

First Name _____ **Last Name** _____

Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Email _____

If the patient is under 17 years old, confirm that this point of contact:

☐ Can access medical information ☐ Can access billing information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Street Address #1 _____ **Street Address #2** _____

City _____ **State** _____ **Zip Code** _____

Goodside Health

ADDITIONAL PARENT/GUARDIAN INFORMATION

Relationship to Patient:

☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Step-father ☐ Step-mother

First Name _____ **Last Name** _____

Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Email _____

If the patient is under 17 years old, confirm that this point of contact:

☐ Can access medical information ☐ Can access billing information

REQUIRED INSURANCE INFORMATION

Goodside Health bills insurance companies to cover the costs of delivering health care services to patients in schools.

Does the patient have health insurance? ☐ Yes ☐ No

If "Yes":

Insurance Provider/Plan Name _____

Member ID Number _____ **Group Number** *(if applicable)* _____

Policy Holder First Name _____ **Policy Holder Last Name** _____

Policy Holder Relationship to Patient _____ **Policy Holder Date of Birth** *(MM/DD/YYYY)* _____

Goodside Health

MEDICAL INFORMATION

If recommended by a licensed medical provider, the following medications (age/weight appropriate) may be administered to the patient at school:

☐ Approve all ☐ Decline all ☐ Let me choose

- ☐ Tylenol/Acetaminophen *(pain/fever)*
- ☐ Advil/Motrin *(pain/fever)*
- ☐ Hydrocortisone Cream *(inflammation/itch)*
- ☐ Antibiotic Ointment/Bacitracin *(cuts/infections)*
- ☐ Benadryl/Diphenhydramine *(allergic reaction)*
- ☐ Throat Lozenge/Benzocaine/Menthol *(cough, sore throat)*
- ☐ Zofran/Ondansetron *(nausea, vomiting)*
- ☐ Claritin/Loratadine *(allergies, allergic reaction)*
- ☐ Cough Syrup/Dextromethorphan/Guaifenesin *(cough)*
- ☐ Tums/Calcium Carbonate *(upset stomach)*

PRIMARY CARE PHYSICIAN & PHARMACY

Goodside Health uses this information to coordinate with the patient's doctor and inform them of any Goodside Health visit. Providing telephone and fax numbers will allow Goodside Health to send a visit summary to the patient's physician.

Does the patient have a primary care physician? ☐ Yes ☐ No

_____ _____

Physician's First Name **Physician's Last Name**

_____ _____

Physician's Phone Number **Physician's Fax Number**

Do you consent to share this health record with your care physician? ☐ Yes ☐ No

What is the patient's preferred pharmacy?

_____ _____

Pharmacy Name **ZIP Code**

Patient/Student Name: _____

Goodside Health

AUTHORIZATION

☐ **I have read the Goodside Health SchoolMed Services Authorization and Privacy policy and I give permission for the patient to receive health care services from Goodside Health providers.**

(Goodside Health SchoolMed Services Authorization and Privacy Practices can be found at https://goodsidehealth.com/terms-conditions/)

☐ **I consent for the patient to receive an annual Well Child Care Visit* from Goodside Health during a Well Care Event at the patient's school.**

*A Well Child Care Visit – also known as a Well Child Check or Child Health Check-up – is a recommended preventative health care service that considers the physical and emotional needs of the patient. Goodside Health will provide Well Child Care Visits at certain participating Schools. With this consent, the patient will receive a Well Child Care Visit if this service is provided at the patient's school.

Patient Name

Patient or Parent/Guardian Signature

Today's Date