Florence 1 Schools
Students first

School Based Health Center (SBHC)
CONSENT FOR RELEASE OF EDUCATION RECORDS & INFORMATION

Florence 1 Schools (the District) shall obtain written consent before disclosing any personally identifiable information from an education record. I understand that the District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other educational or personally identifiable confidential information (i.e., absences, academics or nurse visits), as necessary, to representatives of the School Based Health Center. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected.

_____	_____	_____
Parent/Legal Guardian (*Printed)*	Student's Name *(Printed)*	Student's Date of Birth

_____	_____	_____
Parent/Legal Guardian Signature	Relationship to Student	Date

HOPEHEALTH
YOUR HEALTH BEGINS HERE

Timmonsville School-Based Clinic

SCHOOL BASED HEALTH CENTER REGISTRATION

Patient/Student Information

Last Name	First Name		Middle Initial
Date of Birth	Sex	Race	Social Security Number
Street Address and Zip Code	School Attending: □ Brockington Elementary □ Other	Preferred Language	**2025-2026 School Year**

Parent/Guardian Information

Last Name	First Name	Social Security Number

Phone Number Cell:

Other:

Address (if different from above) Email Address:

Emergency Contacts (other than above)

Name	Number	Relationship

CONSENT FOR TREATMENT

I hereby authorize HopeHealth, Inc. School Based Health Center to provide (both in person and through telemedicine) medical, dental, vision, nutrition, social worker and/or Life Skills Counseling services including but not limited to a medical and/or dental examination, testing, health education, counseling, immunizations, or medical/dental treatments as services provided in the SBHC, and to release information about my child's medical condition as may be ordained necessary or advisable by the attending professional. I understand that such communication may involve the school's nursing staff, teacher, and/or Principal. I understand that this consent is voluntary and is valid only for services provided at the School Based Health Center. I also understand that by signing this form I am giving permission for HopeHealth, Inc. to bill my insurance company for services provided and access to Power School provided by the school district.. I understand that I am responsible for charges not covered by my insurance company.

Consent for Dental (cleanings, fluoride, sealants) ☐
Consent for Medical ☐

Signature of Parent/Guardian: _____ Date: _____

*** Printed Name of person filling out this form _____**

WELL CHILD CONSENT FOR TREATMENT

HopeHealth, Inc. reserves the right to perform a well-child visit when deemed necessary by the Provider. If one has not been performed by a HopeHealth provider within the past 12 months, one will be performed prior to the student receiving vaccinations or a sports physical. The well child visit includes the administration of certain school required and CDC recommended immunizations. Immunizations given at this location include: Diphtheria ,Tetanus, and Pertussis(DTAP), Tetanus, Diphtheria, and Pertussis (Tdap), Polio (IPV), Measles, Mumps, and Rubella (MMR), Hepatitis A, Hepatitis B, and Varicella

Signature of Parent/Guardian: _____ Date: _____

*** Printed Name of person filling out this form _____**

HEALTH INSURANCE INFORMATION

Medicaid Number (if applicable) __ __ __ __ __ __ __ __ __ __

Private Insurance _____ Policy Number _____

Name of Insured _____ DOB Insured _____

ACKNOWLEDGEMENT

Notice of Privacy and Patient Rights and Responsibilities are provided with this form or, at time of visit.

What **healthcare provider** does your child usually see? _____

What **pharmacy** do you use? _____

Student Health Information

Last Name	First Name	Grade

Please circle any of conditions your child has experienced or currently has:

Yes	**No**	Chest Pain (angina)	**Yes**	**No**	Blood in urine
Yes	**No**	Shortness of breath	**Yes**	**No**	Headaches/Fainting/Blurry vision
Yes	**No**	Fever/Night Sweats	**Yes**	**No**	Seizures
Yes	**No**	Persistent cough	**Yes**	**No**	Excessive thirst/dry mouth
Yes	**No**	Bruise easily	**Yes**	**No**	Frequent urination
Yes	**No**	Sinus problems	**Yes**	**No**	Jaundice
Yes	**No**	Difficulty swallowing	**Yes**	**No**	ADHD/ADD
Yes	**No**	Vomiting/nausea	**Yes**	**No**	Depression/Anxiety
Yes	**No**	Heart Disease	**Yes**	**No**	Hepatitis
Yes	**No**	Heart Attack/defects	**Yes**	**No**	HIV/Aids
Yes	**No**	Heart Murmur	**Yes**	**No**	Tumor/cancer
Yes	**No**	Rheumatic Fever	**Yes**	**No**	Arthritis/Rheumatism
Yes	**No**	Autism	**Yes**	**No**	Eye/Skin Disease
Yes	**No**	Stroke/hardening of arteries	**Yes**	**No**	Anemia
Yes	**No**	High Blood Pressure	**Yes**	**No**	VD (syphilis or gonorrhea)
Yes	**No**	Asthma/TB/emphysema	**Yes**	**No**	Herpes
Yes	**No**	Lung Disease	**Yes**	**No**	Kidney/bladder disease
Yes	**No**	Stomach problem/ulcers	**Yes**	**No**	Thyroid/adrenal disease
Yes	**No**	Diabetes	**Yes**	**No**	Psychiatric Care
Yes	**No**	Radiation/Chemotherapy	**Yes**	**No**	Prosthetic Heart Valve
Yes	**No**	Artificial joint	**Yes**	**No**	Hospitalization/Surgery
Yes	**No**	Blood Transfusion	**Yes**	**No**	Pacemaker
Yes	**No**	Recreational drugs	**Yes**	**No**	Tobacco in any form
Yes	**No**	Alcohol	**Yes**	**No**	Drugs, Medicine, OTC

Other condition(s) not listed_____

Family history of any condition(s) listed above_____

Does your child have **allergies**? Please list: _____

Does your child take any **medicines**? YES or NO If yes, please list: _____

Has your child been seen in the **emergency room** in the past year? For what reason?

What **surgeries** has your child had? At what age?