PEDIATRIC ASSOCIATES INC. SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES
Consent Form

Pickerington Local School District (PLSD) AND PEDIATRIC ASSOCIATES INC. ("PAI") are partnering to offer School-Based Supplemental Health Services to PLSD students. The goal of this program is to improve the health and well-being of students so that they can be successful in school. The purpose of the school health services offered is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. This program does NOT replace your regular source of healthcare. School nursing and emergency services will be provided whether you consent to participate in the program or not.

Patient/Student Name **Grade** **Parent/Guardian if Patient/Student is less than 18 years**

Street Address **City** **State** **Zip Code**

( ) - -

Area Code **Phone Number** **Student Date of Birth (Month-Day-Year)** **Sex**

Consent for Medical Care/Treatment

In order for students/patients to receive care through this program, their legal guardian must complete and return this consent form, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent.

By signing below, I represent and acknowledge that I have legal right to consent to medical treatment for the above-named patient/student. I understand that if I am not the child's birth parent, I must attach a copy of proof of legal guardianship to this consent form. If the legal guardian of the student/patient changes, I understand that a new consent form must be signed by the new guardian.

I understand I have the right to make informed decisions about the patient/student's health care treatment. I understand that medical treatment may have certain risks and benefits which will be explained to me by the practitioner.

I understand that this consent will remain valid throughout the student's enrollment at PLSD unless revoked. I understand that I have the right to refuse any procedure or treatment, and I understand that I may revoke this consent for treatment at any time by making a written request to PLSD to have the patient/student removed from services.

I agree to tell PAI about changes in insurance coverage, and to notify the school office manager with all updates or changes to my child's health condition(s), immunization records, or medications.

A visit summary will be provided any time the child is seen in the clinic, however, I understand that the youth's consent may be legally required for release of information related to certain diagnoses and treatment, such as pregnancy, sexually transmitted diseases, and alcohol and drug or mental health counseling.

Choose <u>one</u> of the following:

☐ I consent to allow PAI health care providers who are providing services at Tussing Elementary to perform **<u>all</u>** health care services/treatments, including but not limited to, vital signs, medications, immunizations, and other tests or treatments that, as determined by the practitioner, may be needed to diagnose, treat, and/or care for the needs of the above-referenced patient/student. The services may include, but are not limited to the list below.

-***OR***-

☐ I consent to allow the PAI health care providers who are providing services at Tussing Elementary to perform **<u>only the following</u>** services/treatment for the above-referenced patient/student:

- ☐ Care and treatment for any injury/illness Physical
- ☐ Examinations
- ☐ All immunizations recommended but not required by the Ohio Department of Health
- ☐ HPV immunization
- ☐ Influenza (flu) immunization
- ☐ Pneumococcal immunization
- ☐ Hepatitis A immunization
- ☐ Age-appropriate immunizations for school attendance (DTaP,Tdap, Polio, MMR, Varicella, HepB Meningococcal - following the American Academy of Pediatrics immunization schedule)
- ☐ Mental/Behavioral health counseling
- ☐ Pregnancy testing
- ☐ Birth Control
- ☐ Sexually Transmitted Infection (STI/STD) testing and treatment

Does the Patient take any medications every day? Please list: _____

Does the Patient have any allergies? Please list: _____

Does the Patient have any chronic health conditions? Please list: _____

Notice of Privacy Practices Acknowledgement I have been notified that PAI's Notice of Privacy Practices is available to me at Tussing Elementary upon my request. I can also view them online at www.kidzdoc.com.

Authorization to Release Information I hereby authorize PAI and Pickerington Local School District (PLSD) to share/release/exchange information about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school for treatment purposes, care coordination and/or educational purposes. PAI may request access to my child's academic, attendance and behavior records for the current, prior and future school years so that they can provide better services to my child and understand the impact of their program. I understand this information will be kept confidential in accordance with all state and federal laws. I also hereby authorize PAI to share/release/exchange all such information with my doctors, my referring doctors, or referring/referral health care providers, and/or to any insurance company or organization that helps pay my bill. PAI may also give information to any welfare organization, to which I have applied or may apply for aid. Administered immunizations will be entered into the statewide immunization information system, *Ohio ImpactSIIS*. I understand that PLSD is covered under the federal regulations that govern the privacy of educational records and that any personal health information disclosed under this authorization may be protected by those regulations. Re-disclosure of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal Rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987). My/my child's records are protected and can only be accessed by authorized users with restricted access. I understand that this authorization will remain valid throughout my child's enrollment at PLSD unless I revoke this authorization. I may revoke this authorization at any time by providing written notice of my intent to revoke to PLSD and/or PAI. I understand that I am not required to sign this authorization form. The health information used and/or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. Neither PAI nor PLSD is responsible for the use of information, in whole or in part, by third parties. I have received a copy of this form and I understand that I have the right to inspect or copy any health information disclosed (reasonable copying fees may apply to any copying services). This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity.

Assignment of Insurance Benefits I assign to PAI, all rights and claims for reimbursement under any private health insurance policy, Medicaid, or any other programs that I identify for which benefits may be available to pay for services provided to me through the School-Based Supplemental Health Services. I understand that if I have no insurance coverage, out-of-network coverage or inactive insurance coverage I may receive a bill from PAI.

X_____	**X**_____	**X**_____	**X**_____
Parent/Guardian *Printed Name*	**Parent/Legal Guardian *Signature*** (if student is less than 18 years)	**Date/Time**	**Phone**

_____ _____

Relationship to Student **Parent/Legal Guardian Date of Birth**

X_____	**X**_____	_____
Student (Patient) *Printed Name*	**Student (Patient) *Signature*** (if 18 years or older)	**Date/Time**

Pediatric Associates Inc. will bill insurance and you will receive a statement for any unpaid services. Please answer the information below about your insurance coverage.

We do not have insurance. We plan to pay ourselves. _____ -OR-

This **person carries the insurance** for our student. _____

This person's phone number is: _____

The person who carries the insurance has this **date of birth**: _____

This person is employed by: _____ -OR- not employed _____.

The name of our insurance company is: _____

The group number for our policy is:_____

The policy number for the student is: _____

The claims address is : _____

The phone number for customer service is: _____