



School-Based Health Clinic Consent Form

Student Name: _____

Date of Birth: _____

General Consent for Care and Treatment Consent

- ☐ I give consent for the above-named student to receive health care services provided by Gifford's School-Based Health Clinic (SBHC), including primary and preventive health care, mental health counseling, health screenings, comprehensive and sports physicals, acute care for minor illness and injury, immunizations, prescription medication and care for chronic conditions.
- ☐ I understand that my insurance may be charged for this visit.
- ☐ I understand that I may withdraw this consent at any time, either orally or in writing, by notifying Gifford's SBHC. Otherwise, it will apply for the duration of my child's enrollment in the school district.
- ☐ By signing below, I authorize all designated health center staff to provide necessary examinations, tests, evaluations, management, and treatment of my child's health care in accordance with applicable laws.
- ☐ I understand that in the event of an accident or serious illness, the school will make all reasonable attempt to contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements are deemed necessary.
- ☐ I understand that under Vermont State Law, my child may consent for certain health care services without parental permission and unless failure to notify parents or guardian would seriously jeopardize the health of the minor.

Responsibility for Payment and Assignment of Benefits

- ☐ I understand that I am responsible for paying all costs associated with services provided to my child by the SBHC. I understand Gifford may bill my insurance (including Medicaid) or other third parties for these services. I authorize and assign payment of benefits directly to Gifford Health Care for services rendered. If I have insurance, I understand that all costs and fees not covered by insurance will be my responsibility.

HIPAA and Notice of Privacy Practices

- ☐ I understand that the SBHC must keep health information confidential, but may use and disclose health information for treatment, payment, or healthcare operations. I understand that a detailed list of allowed uses and disclosures is included in Gifford's Notice of Privacy Practices. For your convenience a copy of our Patient Privacy Notice is available on our website: www.giffordhealthcare.org/privacy-notice. To request a paper copy, please call (802) 728-2477.
- ☐ I understand that records and information may be exchanged between SBHC staff and my child's school with my authorization or when otherwise permitted by law without my authorization.
- ☐ I understand the SBHC, my child's medical, dental and mental health care providers, may exchange information about my child and the school nurse in order to provide treatment.
- ☐ I authorize any referral to my child's primary care provider for health care that cannot be provided on site.
- ☐ I understand the SBHC may release information regarding treatment to third-party payers or others for the purpose of billing or for any reason that may be required to comply with the statutes or regulations in accordance with accepted medical practice.

I acknowledge that I have read the information described above and agree to enroll my child in Gifford's School Based Health Clinic at this time. I understand and agree with all the above statements. I understand that I may call the clinic if I have questions.

Signature of Parent/Legal Guardian

Print Name

Date



FERPA Consent to Allow Data Sharing from OSSD to Gifford SBHC:

Student Name: _____ Date of Birth: _____

Student Address: _____

School Name: _____

School Point of Contact: _____

School Contact Info: _____

- ☐ I give permission for my child's school to share information with and discuss my child's health and school performance with my child's health care team as needed and as permitted by law.
 - School staff (role or name): _____
 - Health care team members (role or name): _____
- ☐ I understand that allowing my child's school to share information with my child's health care team will allow them to coordinate my child's care, provide outreach services if necessary, and keep my child healthy, safe, and engaged in school.
- ☐ I understand that, even with this consent, only those individuals at my child's school and health care office who must have access to information about my child will be entitled to participate in discussions or data sharing regarding my child.
- ☐ I understand that, whenever possible, my school will include me in these discussions.
- ☐ I understand that I am entitled to receive a copy of any disclosed records.
- ☐ I understand that these individuals may further use records provided by my child's school or healthcare provider for contacting me and/or verifying information for student health related purposes.
- ☐ I understand that my consent to allow sharing the above information is voluntary and that it is not required for my child to enroll in school or to receive care at my child's doctor. This consent will remain in effect for as long as my child is enrolled in this school district. I understand that I may revoke this consent at any time by submitting a note or letter in writing to the school administration office.

Signature of Parent/Legal Guardian

Print Name

Date

Phone Number (Home)

Phone Number (Cell)