



School Health Services 2025-2026

Please complete one form per student

Grade: _____ School Attending: _____

Last Name: _____ First Name: _____ MI: _____

Student's Social Security # _____ Birthdate: _____

Sex: ___ Male ___ Female Ethnicity: Hispanic or Latino ___ Yes ___ No Primary Language _____

Race: (check one or more): ___ Caucasian/White ___ African American/Black ___ Native American/American Indian ___ Asian

Ethnicity: Hispanic or Latino ___ Yes ___ No

Medication Allergies _____ Other Allergies _____

Food Allergies _____ Dietary Restrictions _____

Street Address _____ City: _____ State: _____ Zip: _____

Parent/Legal Guardian _____ Primary Number _____ Date of Birth _____

Parent/Legal Guardian _____ Primary Number _____ Date of Birth _____

Emergency Contact Person OTHER than Parent/Legal Guardian _____

Relationship to Student _____ Primary # _____ Alternate # _____

Does your student have a KY Medicaid? ___ Yes ___ No Insurance Name and Member # _____

Commercial insurance? ___ Yes ___ No Policy Holder Name: _____

Policy Number: _____ Group Number: _____

No Insurance? ___ Yes ___ No

Does your student have any of the following life-threatening conditions that may require EMERGENCY treatment or medications to be given at school?

Please mark appropriate box(es) below.

- DIABETES (Glucagon) ASTHMA (Rescue Inhaler) SEIZURES (Rescue Medication) LIFE THREATENING ALLERGY (Epi-Pen) OTHER: _____

Significant Medical History _____

Surgical History _____

Significant Family Medical History: _____

Medications Taken Daily _____

*Medications to be given at School _____

**Must complete additional consent form prior to any medications (over the counter or prescription) being brought to school to be administered. Forms are available at school.*

Student's Primary Health Care Provider _____ Phone # _____

Student's Pharmacy: _____ Phone # _____



School Health Services Student Consent Form
2025-2026

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS

Childs Name: _____

Date of Birth: _____

- 1. By signing this form, I consent to school health services that may include screenings, assessments, well child exams (at NO COST to you and NO COPAY will be billed to you because the children's well-child exams are covered 100% by insurance), treatment, first aid, over-the-counter medications, including, but not limited to, the application/administration of anti-itch ointment, antiseptic cleaner, and/or eye wash, Acetaminophen (Tylenol), Ibuprofen (Motrin), Tums, Cough Drops, Benadryl (allergic reactions), Lip Ointment, Burn Cream, Lotion, Sting Relief Swabs, Topical Mouth/ Tooth Pain Relievers (Orajel/Anbesol), Antibiotic Ointment (Neosporin/Bacitracin,etc.) being given to my student by nurses of Access Health while at school. If my student requires emergency medical assistance which cannot be provided on-site by a school nurse and I cannot be reached, I consent to Access Health arranging for the provision of emergency medical care for my student, including, but not limited to, contacting EMS.
2. I understand that when my child is seen by the school nurse for any basic first aid needs (headache, upset stomach, etc) the child will be assessed and then the school nurse will contact a provider at Access Health for a school-based telehealth visit. The parent will not receive a bill for the visit, however should your insurance company deny the claim and you receive a bill please contact our school health coordinator, Elizabeth Frederick directly at 1-606-546-2380
3. If my student participates in Kentucky Medicaid or K-CHIP, I authorize Access Health to release my student's medical information so that Medicaid/K-CHIP can be billed for services provided by the provider at Access Health, at no cost to me.
4. I understand that, by signing this consent, I acknowledge that I received or have access to a copy of Access Health's Notice of Privacy Practices located on the web at access.mymedaccess.com/public-forms or I may request a copy by calling the School Health Coordinator, Elizabeth Frederick at 1-606-546-2380
5. I understand that Access Health does not offer any health service or mental health service related to human sexuality, contraception, or family planning as defined and addressed in KRS 158.191. No such service shall be offered to my child without prior notification to me of that service and written consent for the provision of that service, unless and/or except pursuant to federal, state, or local law.

X _____
(Signature of Parent / Legal Guardian / Emancipated Student)

_____/_____/____
(Date signed)

CONSENT FOR RECEIPT AND DISCLOSURE OF STUDENT MEDICAL INFORMATION

- 1. I hereby consent to Access Health releasing medical information about my student the Health Care Provider as necessary for purposes of treatment or settlement of the billing claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release Access Health from any liability resulting from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payer pursuant to KRS 214.420.
2. Kentucky law requires certain immunizations for attendance in Kentucky public schools. To the extent I provide, directly or indirectly through a third-party medical provider, the required immunization information, I consent to Access Health entering that immunization information into the Kentucky Immunization Registry ("KYIR") on behalf of and as part of its services to Knox County Public Schools ("KCPS"). Further, I consent to Access Health sharing the same records with the Kentucky Cabinet for Health and Family Services and its divisions, subparts and/or employees for the purposes of compiling statistical data, to help control, abate and/or otherwise affect the spread of infectious disease, and/or as otherwise required by law
3. I understand that nothing in this Consent and Disclosure of Student Medical Information is intended to impede, reduce, increase or have any other effect on any right that I have as a parent or legal guardian regarding access to my child's medical information.
4. This consent form will remain in effect for your student through the school year noted above, unless you revoke this consent in writing at any time, except any such revocation will not affect information that has already been released in reliance upon this consent.
5. Any information released in response to this consent may be re-disclosed to other parties. You have a right to receive a copy of this consent form

X _____
(Signature of Parent / Legal Guardian / Emancipated Student)

_____/_____/____
(Date signed)