



**Parental Consent and Registration for Services
Mercy Health – Sayler Park School Health Center**

☐ **Yes**, I give permission for my child to receive services provided by the Mercy Health Center at Mt. Washington School, a school-based health center (SBHC), and as determined by the Center's medical staff.

- ☐ The consent will remain in effect until my child is no longer enrolled in Mt. Washington or until I revoke consent in writing. It is my responsibility to notify the school about changes in legal guardianship.
- ☐ I understand that the SBHC will notify me about seeing/treating my child. This will be done by telephone or in writing.
- ☐ I authorize the SBHC and its staff to communicate with my child's doctor/clinic about care/services.
- ☐ I authorize the SBHC to bill my health insurance provider for services rendered.

Child/Patient's Name _____ **Date of Birth** _____ **SS #** _____
Last First Middle

School _____ Mt. Washington School _____ **Grade** _____

Child/Patient's Sex _____ **Race/Ethnicity** _____

Parent Phone # _____ **Cell #** _____ **Work #** _____

Home Address _____ **City** _____ **State** _____ **Zip Code** _____

Parent/Guardian's Name _____ **Parent Date of Birth** _____ **Parent SS #** _____
Last First Middle

Child/Patient Allergies (including medications) _____

Emergency Contact (other than listed parent) _____ **Relation** _____ **Phone #** _____

Name of Primary Doctor or Clinic _____ **Phone #** _____

Preferred Pharmacy _____ **Phone #** _____

Would you like your child's annual well child exam completed at the SBHC? YES NO

Would you like your child's required immunizations completed at the SBHC? YES NO

Name of Health Insurance or HMO _____

If parent/guardian's policy, insured parent's name and date of birth _____

Medical Card or Insurance Member ID _____ (Please provide a copy of insurance card)

Confidentiality: The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. However, I understand that at times it may be necessary for team members of the SBHC to confer amongst themselves and the school health assistant about health issues related to my child. I understand that, as a courtesy, a record of any service or care to my child at the SBHC will be forwarded to his/her family doctor or clinic. I understand that data not specific to an individual child may be used to evaluate the program.

Mercy Health – Sayler Park School Health Center

Signature of Parent or Legal Guardian _____

Date _____

Child Health History

Name of Child _____ Date of Birth _____

Please provide the following information, which will help us provide health care to your child. All information will be kept confidential, in accordance with the HIPAA privacy rule.

Does your child take any daily prescribed medications? YES NO

If YES, please list _____

Does your child take any over-the-counter (OTC) medications regularly? YES NO

If YES, please list _____

Please let us know your Child's health history by listing or checking off any of the chronic health conditions below:

☐ Asthma ☐ Diabetes ☐ Heart murmur/cardiac condition ☐ Anemia ☐ elevated Lead Level
☐ Seizures ☐ ADHD ☐ Depression ☐ Anxiety

☐ Other Health Conditions-Please list: _____

Has your child had any operations, hospitalizations, or serious accidents? YES NO

If YES, please provide description, dates _____

When was your child's last well check/annual exam? _____

Is your child up to date on immunizations? YES NO DON'T KNOW

Has your child's doctor recommended any restrictions of activity for your child?

YES NO If YES, please list restrictions _____

Please let us know your family's health history by listing or checking off any of the chronic health conditions below:

☐ Diabetes ☐ Asthma ☐ Heart Disease ☐ Substance Abuse ☐ Depression/Anxiety

☐ Other Health Conditions-Please list: _____

Please list all persons living in child's home and relationship to child
