



School Based Health Center Program

Offering: Medical Care and
Behavioral Health Counseling Services

Grade: _____

School: _____

Date: _____

www.integratedhealthservices.org

PARENTAL/GUARDIAN PERMISSION FORM CONCERNING TREATMENT

This form concerns treatment your child can receive through the School Based Health Center (SBHC) operated by Integrated Health Services, Inc (IHS). IHS's services are described in the brochure "Your School Based Health Center". If your child is under 18 years of age, IHS cannot provide SBHC services until you have read the brochure, sign and date this permission form and the HIPPA form and return the forms to the SBHC at your child's respective school.

Student Information: Please Print

Student's Name: _____ Sex: ☐ Female ☐ Male
Last First Middle
Address: _____ City: _____ Zip Code: _____
Birth Date: _____ Home Phone: _____ Social Security No. _____
Race: (Please Check One) ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American/Haitian
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Parent/Guardian Information:

Name: _____ Home #: _____ Cell Phone #: _____
Address: _____ Work #: _____
Relationship to student: ☐ Parent ☐ Guardian ☐ Other _____
Number of people living in household: _____ Combined yearly household income: \$ _____

Student Insurance Information: Please select all that applies

1. **Medicaid/Husky:** Childs Medicaid # _____
2. **Private Insurance Carrier Information:**
Insurance Co. Name _____ Policy #: _____ Group #: _____
Employee Name: _____ Employer Name: _____
Employee DOB: _____ Relationship to Child: _____
3. **My Child does not have any insurance coverage:** _____ Please give reason: _____

DENTAL Insurance Information:

- A) Insurance Company Name: _____ Policy #: _____
B) ☐ My Child Does Not Have Any Dental Insurance

Primary Source of Medical Care Information:

Primary Care Doctor Name: _____ Phone #: _____
Primary Pharmacy Name: _____ Phone #: _____
No Primary Care Doctor, Child Gets Medical Care From:
☐ School Based Health Center ☐ Hospital/Clinic ☐ Military Clinic ☐ Emergency Room
☐ Community Health Center ☐ Urgent Care Center ☐ No Regular Source ☐ Private Doctor

Student Name: _____ DOB: _____ Grade: _____

Student Medical History:

Current Medications: <i>(Please list all medications presently being taken including any over the counter meds)</i>			

Medication Allergies: _____		Other Allergies: _____	
Age of First Menstrual Period: _____		Accidents: _____	
Hospitalizations: _____		Surgeries: _____	
Injuries: _____		Other Illnesses-Please Specify: _____	
Overdoses/Poisonings: _____		_____	
Please ☒ any problem the STUDENT has or had:			
YES/ NO	YES/NO	YES/NO	YES/NO
____/____ Addiction to Drugs/Alcohol	____/____ Emotional Issues	____/____ High Blood Pressure	____/____ Rheumatic Fever
____/____ Allergies	____/____ Eye Problems- glasses	____/____ Joint Pain	____/____ Skin Problems
____/____ Anemia/Blood Disease	____/____ Diabetes	____/____ Kidney/Bladder Problems	____/____ STD's
____/____ Asthma	____/____ Dizziness/Fainting	____/____ Menstrual Problems	____/____ Swollen Glands
____/____ Back Pain	____/____ Frequent Headaches	____/____ Migraine Headaches	____/____ Urinary Infections
____/____ Broken Bones	____/____ Frequent Sore Throats	____/____ Mononucleosis	____/____ Vaginal Infections
____/____ Chicken Pox	____/____ Frequent Stomachaches	____/____ Pelvic Disease	____/____ Weight Problems
____/____ Ear Problems-Hearing	____/____ Heart Murmur	____/____ Pregnancy	Other: _____

Family History:

Has anyone in your FAMILY had any of the following? If <u>yes</u> please ☒ and give their relationship to student.					
YES	Relationship	YES	Relationship	YES	Relationship
____ Arthritis _____		____ Heart Disease _____		____ Respiratory Disease _____	
____ Asthma _____		____ High Blood Pressure _____		____ Seizure Disorder _____	
____ Blood Disorder _____		____ Kidney Disease _____		____ Stroke _____	
____ Cancer _____		____ Mental Illness _____		____ Substance Abuse _____	
____ Diabetes _____		____ Migraines _____		____ Tuberculosis _____	
____ Female Problems _____		____ Thyroid Disease _____		____ Other _____	

I have read the brochure "Your School Based Health Center" which lists services provided by Integrated Health Services *SBHC program to children within your "Designated School". I give my child permission to receive any services offered by IHS at the SBHS. Services may be rendered face to face or using telehealth which may include video or phone calls. I am aware that this form will serve as permission throughout their transition from elementary to high school unless I submit a written request to terminate this agreement. I understand that student visits to the SBHC are confidential and information will be released by SBHC only in compliance with the law. I authorize IHS to exchange Health and Education records with my child's school district for the purpose of providing care and treatment. I give the SBHC permission to release information regarding treatment and/or services, including those related to Mental Health, HIV, and AIDS to my insurance providers for the sole purpose of billing. I hereby assign all my rights for payment to IHS, and authorize that insurance payments be made directly to Integrated Health Services, Inc. for services provided to my child at the SBHC.

Parent/Guardian Name (Please Print) _____

Phone Number _____

Parent/Guardian Signature _____

Date _____