HERRON
HIGH SCHOOL

HERRON-RIVERSIDE
HIGH SCHOOL

HERRON
PREPARATORY
ACADEMY

CONSENT FOR SCHOOL-BASED, FEE-FOR-SERVICES
PROVIDED BY NURSE PRACTITIONER OR SOCIAL WORKER
HERRON CLASSICAL SCHOOLS

STUDENT'S LEGAL NAME: _____ SCHOOL YEAR: _____

1) <u>I give consent for my child to receive school-based services:</u> My consent will allow my child to receive healthcare services while he/she is a student at Herron Classical Schools. If I change my mind, I must write a letter to the school-based healthcare office stating my intentions. It will also be my responsibility to notify the school-based healthcare office staff about changes in any guardianship, address, phone number, and email address. I am aware the healthcare office cannot take care of all medical needs my child may have.

Services may include:

- Upper Respiratory/Sinus Infections
- Reproductive Health
- Mental Health/Counseling Services
- Headaches
- Rashes
- Sports Physicals
- Eye/Ear Pain
- Sore Throat
- Asthma/Allergies

2) <u>Information Policy</u>: I have had an opportunity to receive and review a detailed copy of the **NOTICE OF PRIVACY PRACTICES** to help me understand Herron Classical Schools' policies with regards to my child's personal health information prior to signing this consent. It has been explained to me that the terms of the notice may change from time to time and that the current notice will be posted on Herron Classical Schools' website.

3) <u>Release of Information:</u> I understand the services provided by the school-based healthcare office are confidential. The school-based health-care office will use and disclose my child's personal health information to provide treatment and for improvement of healthcare operations. My child's information may be shared with their doctor or primary care physician, school-based healthcare staff, or the social worker for legitimate purposes. I authorize the release of my child's medical information to other physicians and providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation.

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ Date: _____

ANY SERVICES OTHER THAN <u>EMERGENCY TREATMENT</u> WILL NOT BE PROVIDED WITHOUT A SIGNED CONSENT AS REQUIRED BY INDIANA LAW.