

IFM Community Medicine School Health Program
Parental Consent Form (Grades PK-12)
Ritenour School District

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
Student's Last Name: _____ Student's First Name: _____ Date of Birth: _____ / _____ / _____ Month Day Year Student's Social Security Number: _____ Sex: ☐ Male ☐ Female Grade _____ Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Other _____ Student Address: _____ _____ _____ City State Zip Code Who is the student's regular doctor? Name: _____ Telephone: _____ Address: _____ _____ _____	<u>Mother</u> Last Name: _____ First Name: _____ <u>Father</u> Last Name: _____ First Name: _____ <u>Legal Guardian, If Applicable</u> Last Name: _____ First Name: _____ Relationship of legal guardian to student ☐ Grandparent ☐ Aunt or Uncle ☐ Other: _____ <u>Contact Information for parent or guardian</u> Home Tel: _____ Work Tel: _____ Cell: _____ <u>Additional Emergency Contact</u> Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____ Cell: _____
INSURANCE INFORMATION	
Does your child have Straight Medicaid? ☐ No ☐ Yes: Medicaid ID # _____ Does your child have MoHealthnet? ☐ No ☐ Yes: CHP # _____ Which Plan? _____	Does your child have other insurance? ☐ No ☐ Yes: Insurance Company: _____ Group Number: _____ ID Number: _____ -
PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES	
I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the IFM COMMUNITY MEDICINE School-Based Health Center. NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention for students over 13 years of age, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. X _____ Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) _____ Date	
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION	

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SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of IFM COMMUNITY MEDICINE as part of the school health program approved by the Ritenour School District. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and *required and recommended immunizations*.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the school-based health center.
8. Vaccines required by the State for school attendance.

Time Period During Which Healthcare Services are Authorized:

The 2026-2027 School Year

HIPAA Authorization for Use or Sharing of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your signature may be required in certain circumstances before your health information may be used or shared.

This authorization permits IFM Community Medicine to release certain medical information as stated below. You may refuse to sign this Authorization. You will not be refused health care treatment if you do not sign this Authorization. You may sign this form and later change your mind by sending a letter to IFM. You can request a copy of this form.

IFM Community Medicine may use or disclose my medical information regarding treatment or payment for services. IFM may share information with insurance companies for payment and your primary care provider (if applicable) and others for treatment.

I understand that IFM Community Medicine will make a good faith effort to release only the minimum amount of necessary information needed to carry this out.