NATIONWIDE CHILDREN'S HOSPITAL SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Office Use Only
Patient ID:

Your child's school district ("School District") and Nationwide Children's Hospital ("NCH") are partnering to offer School-Based Supplemental Health services (including Behavioral Health) to School District's students. The goal of this program is to help improve the health and well-being of students so they can be successful in school. The purpose of the school health services offered is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. We are NOT trying to replace your regular source of healthcare. **School nursing (where available) and emergency services will still be provided as always whether you consent to participate in the program or not.**

Student / Family Information (Print all information in ink.)			
Student's First & Last Name:	**Student's Date of Birth** (month/day/year)**:**	**School:**	**Grade:**
Parent/Guardian First & Last Name:	**Relationship to Student:**	**Phone Number:**	**Preferred Language:**
Street Address:	**City:**	**State:**	**Zip Code:**

Health Provider Information	Insurance Information
Date of student's last physical_____ ☐No physical in last 12 months Doctor's Name/Address/Phone_____ Pharmacy Name / Location_____	☐Medicaid ☐Molina ☐Caresource ☐Other ☐Private Insurance Plan Insurance Name_____ Insurance address_____ Group & ID #_____ ☐NONE, please connect me to NCH financial counselor. *All services provided are billed to insurance. If you do not have insurance, NCH will connect you to financial assistance. No child is denied services for inability to pay.*

I consent to allow the NCH health care providers who are providing services to perform the following services / treatment and vaccines for the above referenced student:

Consent for Medical Care / Treatment	
Below, place an X next to each service.	
☐	Care and treatment for any injury/illness
☐	Physical examinations / well-child (i.e. sports, work, school) **Note**: Well-child care includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate.
☐	Behavioral Health early brief individual intervention, prevention, and wellness groups. Skill Building – social emotional learning and development of coping skills. (Your insurance won't be billed for brief individual intervention, prevention, and wellness groups)

Consent for Vaccinations

☐ I want my child to receive **all available vaccines**
☐ I want my child to receive **only the selected vaccines below** (check all that apply).

	Required Vaccines for school attendance in Ohio (below). This means Ohio law says your child must have these vaccines to go to school.		**Recommended Vaccines** (Age appropriate, following the American Academy of Pediatrics vaccination schedule) (Below). This means doctors urge your child to get these vaccines, but they can still go to school without them.
☐	DTaP/TDaP/TD	☐	Influenza (Flu)
☐	Meningococcal	☐	HPV
☐	MMR	☐	Hepatitis A
☐	Varicella	☐	Pneumococcal
☐	Polio	☐	HIB
☐	Hepatitis B	☐	Men B

By signing this consent, a copy of which will be provided to me, I agree to the terms and conditions regarding Authorization to Release and Share Information and the Assignment of Insurance Benefits, each set forth on the following page. I also acknowledge that I have received information about how to receive a Notice of Privacy Practices as explained on the following page. I understand that this consent will remain valid throughout the current 12-month academic year commencing August 1, unless revoked. I understand that I may revoke this consent for treatment at any time by making a written request to NCH to have me/my child removed from the services. I have reviewed the School-Based Supplemental Health Services summary information attached to this consent, and I understand the services available. It is my responsibility to tell NCH about changes in insurance coverage, and to notify School District and NCH with all updates or changes to my child's health condition(s), immunization records, or medications. I will be notified of any services my child receives (subject to applicable law), as well as any abnormal findings and/or further treatment recommendations. For questions related to any services my child receives I understand that I should call the phone number listed on the After Visit Summary which will be sent home with my child.

X_____ **X**_____
Parent/Guardian *Printed Name* (if student less than 18) **Parent/Guardian *Signature*** **Date/Time**

X_____ **X**_____
(if student 18+) Student *Printed Name* **Student *Signature*** **Date/Time**

Student Health History

Select and describe if your student has or has had any of the following:

Medications ☐ YES (list below) ☐ NO	**Allergies** ☐ YES (explain below) ☐ NO	**Surgeries (when?)** ☐ YES (explain below) ☐ NO	**Other medical problems or health concerns** ☐ YES (explain below) ☐ NO
1)	1)	1)	1)
2)	2)	2)	2)
3)	3)	3)	3)

Please explain any other medical information:

Historical Questions

Is your child likely to faint or become light headed with shots or blood draws? ☐ Yes ☐ No

Does your child have any allergy to egg, latex, polymycin, neomycin, gentamicin, gelatin, or any foods? ☐ Yes ☐ No

Has your child ever had a serious reaction after getting a vaccine? ☐ Yes ☐ No

Does your child have any medical problems with their lungs, heart, kidney, liver or diabetes? ☐ Yes ☐ No

Does your child have anemia, bleeding disorder or take long term aspirin therapy? ☐ Yes ☐ No

Has your child, or siblings or parent ever had a seizure? Has the child had a brain or other nervous system problems? ☐ Yes ☐ No

Has the child ever had Guillain-Barre syndrome? ☐ Yes ☐ No

Is your child being treated for cancer, or any other immune system problems? ☐ Yes ☐ No

In the past 3 months, has the child taken any medications that weaken the immune system, such as steroids, anticancer drugs or had radiation treatments? ☐ Yes ☐ No

In the past year, has the child received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug? EX: Symmetrel, Flumadine, Relenza, Tamiflu ☐ Yes ☐ No

Has the child received vaccinations in the past 4 weeks? ☐ Yes ☐ No

Privacy Practices & Authorization to Release Information

Notice of Privacy Practices Acknowledgement: I have been notified that NCH's Notice of Privacy Practices is available upon my request at any School District building where services are provided. I can also view the Notice of Privacy Practices online at https://www.nationwidechildrens.org/your-visit/medical-records/privacy-notice.

Assignment of Insurance Benefits: Insurance or other health coverage programs are billed whenever possible to help cover the cost of care. I assign to NCH, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for services provided to me through the School-Based Supplemental Health Services. To find out if you are eligible for financial assistance, contact Financial Services at (614) 722-2070 or visit **NationwideChildrens.org/Financial-Assistance.**

Authorization to Release Medical Information: I hereby authorize NCH and School District to share/release/exchange information with school nurses, school counselors, school social workers and/or school administrators about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school for treatment purposes, care coordination and/or educational purposes. I understand this information will be kept confidential. I also hereby authorize NCH to share/release/exchange all such information with my doctors, my referring doctors, or referring/referral health care providers; and/or to any insurance company or organization that helps pay my bill. NCH may also give information to any welfare organization, to which I have applied or may apply for aid. Administered immunizations will be entered into the statewide immunization information system, *Ohio ImpactSIIS*. I understand that School District is covered under the federal regulations that govern the privacy of educational records and that any personal health information disclosed under this authorization may be protected by those regulations. Re-disclosure of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal Rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987). My/my child's records are protected and can only be accessed by authorized users with restricted access. I understand that this authorization will remain valid throughout my child's enrollment at his or her School District for the current 12 month academic year commencing August 1, unless I revoke this authorization. I may revoke this authorization at any time by providing written notice of my intent to revoke to School District and/or NCH. I understand that I am not required to sign this authorization form and that NCH will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization. The health information used and/or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. Neither NCH nor my child's School District is responsible for the use of information, in whole or in part, by third parties. This authorization is given without promise of compensation. I have received a copy of this form and I understand that I have the right to inspect or copy any health information disclosed (reasonable copying fees may apply to any copying services). This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity.