Student Name: _____ Student DOB: _____

# SCHOOL-BASED HEALTH SERVICES CONSENT FORM

Cleveland Metropolitan School District ("CMSD") and Say Yes Cleveland ("SYC") partner with community agencies to offer additional School-Based Health Services. Completion of this consent form is required for your child to receive these health services from CMSD partner health providers. **School nursing and emergency services will be provided whether or not you choose to take part in these added services.**

## Student/Patient Information

Student Last Name: _____ Student First Name: _____

Date of Birth: _____ Sex at Birth (please check): ☐ Female ☐ Male Gender: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ School Name: _____

Preferred Language: _____ Is this student Hispanic/Latino? (please check)? ☐ Yes ☐ No

Race (please check): ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Black/African American ☐ Don't want to answer Other: _____

## Legal Guardian Information (This will be the primary person contacted concerning the student's health)

Guardian's Last Name: _____ Guardian's First Name: _____

Date of Birth: _____ Employer Name (if available): _____

Phone Number _____ Email _____

Relationship to Student _____ Lives with Student? ☐ Yes ☐ No

## Student/Patient Insurance Information (If known)

Child/Teen has insurance (please check): ☐ Yes ☐ No

Name of Insurance Company: _____ Subscriber's Name: _____

Group Number: _____ Subscriber ID: _____

## Emergency Contact Information (other than legal guardian)

Name: _____ Relationship to student: _____

Phone Number: _____ May we leave a message? ☐ Yes ☐ No

## Student Health Information (to be completed by parent/legal guardian) Please check all that apply.

- ☐ Asthma
- ☐ Cancer/Leukemia
- ☐ Eczema
- ☐ Migraines
- ☐ Premature Birth
- ☐ Sickle Cell
- ☐ Spine Disorders
- ☐ Bladder/Urinary Problems
- ☐ Seizures
- ☐ Glasses/Contacts
- ☐ Hearing Aids
- ☐ Mental Health Concerns
- ☐ Blood Disorder
- ☐ Diabetes
- ☐ Pneumonia
- ☐ Kidney/Renal Disease
- ☐ Heart Problem
- ☐ Developmental Problems
- ☐ Bowel Disorder
- ☐ Tuberculosis/TB
- ☐ Tobacco Use
- ☐ Substance/Drug Abuse
- ☐ Past or Current Elevated Lead Level

☐ Other (Please explain): _____

**Student Name:** _____ **Student DOB:** _____

## Primary Care Provider Information

Name of Primary Care Provider/Physician (PCP): _____

PCP Location (please check):

- ☐ Care Alliance
- ☐ Cleveland Clinic
- ☐ MetroHealth
- ☐ Neighborhood Family Practice
- ☐ NEON
- ☐ UH/Rainbow Babies and Children
- ☐ Other: _____

## Preferred Retail Pharmacy

Name: _____ Address: _____ Phone Number: _____

## Patient/Student Allergies

☐ **NO KNOWN ALLERGIES**

☐ **YES**—Please list below:

Food: _____

Medications: _____

Insects: _____

Seasonal: _____

Animals: _____

## Immunization History

Has your child every had a reaction to any immunizations/shots?

☐ Yes ☐ No

If YES, please explain reaction _____

What immunization/shot caused reaction: _____

## Services: Additional school-based health services may include the following services unless you tell us not to.

**Cross out any services you DO NOT want your child to receive.**

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Medication administration (albuterol, epinephrine, antibiotics, prescription and over-the-counter medications)
- Routine lab tests
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Mental/behavioral health assessment, screening, and intervention (additional parental/guardian consent required for children under the age of 18)
- Drug or alcohol use treatment
- Sexual wellness services
- Vision and hearing screening and treatment
- Lead testing/screening
- COVID-19 testing/screening
- Dental screening and services (dental x-rays, sealants, and cleanings; therapeutic fillings, fluoride applications)
- Health education and prevention programs
- Sports medicine services

## Immunizations (shots): Your school nurse and the School Health Program team will review your child's record to determine which shots are needed.

**Cross out any shots you DO NOT want your child to receive.**

**School-Required Immunizations:**

- DTap/Td (diphtheria, tetanus, and whooping cough for children)
- Tdap (tetanus, diptheria, and whooping cough for adolescents)
- Polio
- Hepatitis B
- MMR (Measles, Mumps, Rubella)
- Meningococcal A
- Varicella (Chicken Pox)

**Pediatric/Adolescent Recommended Immunizations:**

- Human Papillomavirus (HPV)
- Influenza (Flu)
- Hepatitis A
- Meningococcal B
- COVID-19 Vaccine

Please visit **http://www.immunize.org/vis/** to find the Vaccine Information Statement for each vaccine, which will explain risks and benefits of all vaccines.

[1]Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf.

**Student Name:** _____ **Student DOB:** _____

## Consent for Health Services/Treatment

By signing below, I consent for my child to receive the additional School-Based Health Services (the "Services") listed below when necessary to promote my child's health. I understand that these Services will be performed by a health provider in partnership with CMSD and that contact information for all partner health providers can be found on CMSD's website at https://www.clevelandmetroschools.org/Page/19754. I also understand that examination and treatment may be in-person or by telehealth. Treatment received using telehealth does not allow for direct contact with a patient and may be affected by transmission quality. If I no longer want my child to receive any of the Services, I may request that they be stopped, and that request will not affect my ability to obtain medical care for my child in the future.

## Agreement of Financial Responsibility

Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. If applicable, I agree to provide complete, accurate, and timely information relating to any available health insurance in order for CMSD partner providers to seek payment in a timely manner. These Services are provided to students whether or not a student has insurance or the ability to pay. I give CMSD partner providers the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which a benefit may be available to pay for Services provided to my child. I have read and understand the information about additional School-Based Health Services available through CMSD partner health providers. My signature provides consent for my child to receive the Services for as long as my child is a student in CMSD. I understand that I can revoke my consent at any time by providing a written request to CMSD.

**Signature of Parent/Legal Guardian (or student if 18 years or older or otherwise permitted by law):**

_____

**Print Name of Parent/Legal Guardian:**

_____

**Relationship to the Child/Student:**

_____

**Date:** _____

## Authorization to Release Health Information

I authorize CMSD partner health providers to provide my child's medical information, including diagnosis, treatment records, vaccinations, and lab results, to CMSD school officials, including SYC staff and third parties, engaged in the facilitation of CMSD's student health and wellness initiatives, for treatment, referral, and/or care coordination. I authorize CMSD and SYC to provide a copy of medical information or other relevant personal information within my child's school records to CMSD partner health providers. I agree to allow CMSD partner health providers to access my child's individual academic, attendance, and behavior records for the current and prior school years so they can provide better services to my child.

I understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol use treatment. CMSD partner health providers may only disclose information relating to such diagnosis, testing, or treatment as directed in this authorization and as allowed under applicable law.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my child's information, it will not in any way prevent my child from receiving care or treatment from any of the providers listed. I understand that I may terminate this authorization in writing at any time, prior to the release of my child's information, though such termination would not impact information released prior to the submission of a written termination notice. I am also aware there is potential for information disclosed under this consent to be redisclosed by the recipient and no longer be protected.

## Notice of Privacy Practices Acknowledgement

I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for CMSD partner health providers. I know that I can also view them online at https://www.clevelandmetroschools.org/Page/19754. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting CMSD partner health providers by phone or in writing. I understand I have the right to ask how my protected health information will be used or given out. I CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CONSENT TO THE RELEASE OF MY CHILD'S INFORMATION AS DESCRIBED ABOVE. I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS DOCUMENT. THIS AUTHORIZATION FORM WILL REMAIN VALID WHILE MY CHILD IS ENROLLED IN CMSD OR UNTIL I TERMINATE IT IN WRITING.

**Signature of Parent/Legal Guardian:**

_____

**Print Name of Parent/Legal Guardian:**

_____

**Relationship to the Child/Student:**

_____

**Date:** _____