PLEASE RETURN PACKET TO CMSD SCHOOL NURSE

Student Name: ______________________________ Date of Birth: ___________

Dear Parent or Guardian:

One of the programs offered to your child at school this year is The MetroHealth School Health Program. This program is very exciting for your child and your school because it helps keep your child healthy and in the classroom.

The School Health Program Clinic services include:

- Sports/school/work physicals
- Immunizations/shots
- Urgent care visits
- Care for common health concerns (asthma, diabetes, etc)
- Well child visits
- Teen health issues
- Mental and behavioral health screenings and referral to in-school services
- Basic lab testing

There is no cost for the health services offered by the School Health Program Clinic at your child's school. Insurance may be billed – but there is never any charges to students or families.

If you would like your child to able to use the services at the school clinic:

1. Fill out the School Health Program Registration (front and back)
2. Sign the School Health Program Consent Form (front and back)
3. Sign the Immunization Form
4. Return all forms in this packet to your CMSD School Nurse

Please return this packet to your CMSD School Nurse and feel free to call your CMSD School Nurse or the MetroHealth School Health Program at 216-957-1303 if you have any questions about the School Health Program.

PLEASE RETURN PACKET TO CMSD SCHOOL NURSE

School Health Program Registration

To register your child or teen for the MetroHealth School Health Program:

1. Complete this form (front & back) AND the attached consent form (front & back)
2. Please use black or blue ink pen to complete
3. If you have questions please contact your CMSD School Nurse or call the School Health Program at 216-957-1303.

Student/Patient Information		
Student Last Name:	Student First Name:	
Date of Birth:	Sex (please circle): Female or Male	Social Security #:
Home Address:		City:
State: Zip Code:		Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic (please circle)? Yes or No	
Race (please circle): American Indian/Alaskan Native Asian Native American/Pacific Islander Caucasian African American Declined Other:		
Name of Primary Care Provider/Physician (PCP):		
PCP Location (please circle): MetroHealth UH/Rainbow Babies and Children Cleveland Clinic Other:		
Legal Guardian Information		
Guardian's Last Name:	Guardian's First Name:	
Date of Birth:	Social Security #:	
Home Phone:	Cell Phone:	
Employer:	Employer Phone:	
Student/Patient Insurance Information		
Child/Teen has insurance (please circle): Yes or No		
Name of Insurance Company:	Subscriber's Name:	
Group Number:	Subscriber ID:	
Emergency Contact Information		
Name:	Relationship:	
Phone Number:	May we leave a message? Yes or No	

School Health Program Registration

Student Health History

Student Name:	Student Date of Birth:

Patient/Student Medical History (please circle all that apply)

Asthma	Cancer/Leukemia	Eczema
Migraines	Premature Birth	Sickle Cell
Bladder/Urinary Problems	Mental Health Issues	Mental Health Issues
Kidney/Renal Disease	Spine Disorders	Pneumonia
Blood Disorder	Diabetes Mellitus	Glasses/Contacts
Bowel Issues/Constipation	Seizures	Hearing Aid

Other: ____

Patient/Student Current Medications (vitamins, inhalers, prescriptions, other)			
Name of Medication	**Dose**	**Amount Taken**	**Times per Day**
Preferred Retail Pharmacy Name:			
Address:		Phone Number:	

Patient/Student Allergies	
☐ **YES** – Please list below:	☐ **NO KNOWN ALLERGIES**
Food:	
Medications:	
Insects:	
Seasonal:	
Animals:	

Patient Hospital/Surgery History	
Past Hospital Stays: Yes or No	Explain:
Past Surgeries: Yes or No	Explain:
ER visits in past year: Yes or No	How many:

Family History (please circle all that apply) and list who has the problem next to it (mom, dad, grandparent, brother, sister)			
Anemia		High Blood Pressure	
SIDS/Sudden Infant Death		Asthma	
Headaches		Stroke	
Diabetes		Alcohol / Drug Abuse	
AIDS/HIV		Cancer	
Arthritis		High Cholesterol	
Heart Disease		Seizures	
Sickle Cell		Tuberculosis/TB	
Mental Health Issues		Other (please list)	

School: _____________________ Student Name:__________________________ Date of Birth:_____________

THE METROHEALTH SYSTEM **AND**
NEIGHBORHOOD FAMILY PRACTICE **AND**
CARE ALLIANCE HEALTH CENTER

SCHOOL HEALTH PROGRAMS CONSENT FORM

I, ________________________________, (the "Parent/Guardian" [1]), in connection with my child, __________________________(the "Student/Child"), participating in the School Health Programs, agree to the following:

The purpose of this Consent Form is to allow parents/custodians/emancipated minors/students over the age of 18 to:

(1) give informed consent for your child to participate in and receive treatment from a MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center physician or healthcare provider through its School Health Program;
(2) acknowledge responsibility for the payment of charges and fees not covered by insurance;
and
(3) enroll your child in MetroHealth Pediatric Wellness Center's nutrition and fitness in –school and after-school classes.
(4) give permission to release your child's protected health information ("PHI") from The MetroHealth System (MetroHealth) and/or Neighborhood Family Practice and/or Care Alliance Health Center to the Cleveland Metropolitan School District School Nurses.

1. Informed Consent for Treatment

The Parent/Guardian consents for your Child to receive necessary and/or advisable medical treatment from a MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center physician or healthcare provider through MetroHealth's or Neighborhood Family Practice's or Care Alliance Health Center's School Health Program. Such medical treatment may include, but is not limited to, physical exams, and immunizations (shots), routine lab tests, care for acute illness and injury, prescription medications, care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems), care of certain chronic conditions (such as asthma, seizure disorders, or diabetes), pregnancy testing, diagnosis and treatment of sexually transmitted infections, drug and alcohol prevention, education, counseling, mental health assessments, and follow-up care as needed.

2. Agreement of Financial Responsibility

If applicable, MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center will bill your Child's insurance carrier(s) for charges and fees covered by your Child's insurance plan. Parent/Guardian agrees to provide complete, accurate and timely information relating to any available health insurance in order for MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center to seek payment in a timely manner. Parent/Guardian understands that a failure to provide complete, accurate and timely information, including any changes in insurance coverage, may prevent the provider from complying with the administrative rules of your Child's insurance plan. Parent/Guardian may obtain a list of usual and customary charges from MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center upon request.

3. Participation in Nutrition and Fitness Classes – METROHEALTH PROGRAM ONLY

If your Child attends a school serviced by MetroHealth, Parent/Guardian agrees to enroll your Child in additional in-school and after-school nutrition and fitness classes to help your Child maintain or reach a healthy weight and lifestyle.

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS CONSENT FORM AND THAT I HAVE RECEIVED INFORMATION ON THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, INCLUDING THE PROCESS FOR FILING A COMPLAINT OR GRIEVANCE.

Signature of Parent/Legal Guardian: ____

[CONTINUE TO BACK PAGE – ANOTHER SIGNATURE NEEDED]

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[1] Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.

School: _____________________Student Name:__________________________ Date of Birth:_____________

4. Release of PHI

I authorize MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center to provide my Child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to Cleveland Metropolitan School District School Nurses for the purpose of treatment, referral and/or care coordination. To help coordinate care, MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center may receive and copy medical information within Child's school records via assistance from Cleveland Metropolitan School Nurses.

This permission will expire when your Child is no longer an enrolled student in the Cleveland Metropolitan School District or when it is terminated in writing.

I understand that my express consent may be required for the disclosure of information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If your Child has been tested, treated, or diagnosed with any such injury, disease, or illness, MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For records related to alcohol and drug treatment, federal law prohibits recipient from making further disclosure of this information unless the additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal 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 PHI, it will not in any way prevent Participant from receiving care or treatment from MetroHealth and/or Neighborhood Family Practice and/or Care Alliance Health Center. I understand that I may terminate this authorization in writing at any time, prior to the release of my Child's PHI.

5. Notice of Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices if my child is a new patient at The MetroHealth System and/or Neighborhood Family Practice and or Care Alliance Health Center. I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for The MetroHealth System and/or Neighborhood Family Practice and/or Care Alliance Health Center at any of the School Health Program sites if my child has been a patient at The MetroHealth System and/or Neighborhood Family Practice and or Care Alliance Health Center in the past. I know that I can also view them online:

The MetroHealth System:
http://www.metrohealth.org/upload/docs/main/Patient%20Visitor%20Information/VII-07BNoticeofPrivacyPractices.pdf
Neighborhood Family Practice
http://www.nfpmedcenter.org/media/documents/Privacy%20Practices%20-%20English.pdf
Care Alliance Health Center
http://www.carealliance.org/wp-content/uploads/2016/05/Notice-of-Privacy-Practices-FY-2016.pdf

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS CONSENT TO RELEASE PHI AND CONSENT TO THE RELEASE OF MY CHILD'S PHI TO CLEVELAND METROPOLITAN SCHOOL DISTRICT SCHOOL NURSES. I, PARENT/GUARDIAN, ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS CONSENT.

THIS CONSENT FORM WILL REMAIN VALID WHILE PARTICIPANT IS ENROLLED IN THE CLEVELAND METROPOLITAN SCHOOL DISTRICT UNTIL TERMINATED IN WRITING.

Signature of Parent/Legal Guardian: ____

Print Name of Parent/Legal Guardian:____

Relationship to the Child/Student:____

Date:____

[1] Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.

Date: School:

Student Name: Date of Birth:

Dear Parent/Guardian:

You have already consented for your child to receive services, this includes immunizations (shots), with the MetroHealth School Health Program. Your school nurse and the School Health Program team will review your child's record to determine which shots your child will need. If your child is up-to-date on their immunizations, please give a copy of your child's shot record to the school nurse.

Please **CIRCLE** any vaccine(s) that you **DO NOT** want your child to receive.

Required

- DTap (Diphtheria, Tetanus, Pertussis)
- Tdap (Tetanus, Diphtheria, Pertussis)
- Td (Tetanus, Diphtheria)
- Polio
- MMR (Measles, Mumps, Rubella)
- Hepatitis B
- Varicella (Chicken Pox)
- Meningococcal (Meningitis)

There are also other shots, while not required for school, **are highly recommended** for children.

Recommended

- Human Papillomavirus (HPV)
- Hepatitis A
- Meningococcal B (Men B)
- Influenza (Flu)

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

An After Visit Summary (AVS) will be sent home with your child after their clinic visit, with an updated shot record.

By signing below, I have read the Vaccine Information Statement and consent, give permission, for the student named at the top of this form to receive the vaccine(s), except for the circled vaccine(s)

Guardian/Parent Signature ____ Date ________________

Printed Name ____

Please return this form with your School Health Program Registration Packet to your School Nurse