School Health Program Registration

To register your child or teen for the MetroHealth School Health Program please complete the front and back of this form and the attached consent form. If you have questions about this program please contact your CMSD School Nurse or call the School Health Program at 216-957-1303.

Patient Information:

Student's Last Name: _____First Name: _____

Student's Address: _____

Student's Sex (please circle): M or F Student's Date of Birth: _____

Student's Social Security Number: _____

Student's School: _____

Race (please circle): White Black Asian Other: _____Hispanic (please circle): Y or N

Primary Care Provider (PCP): _____

PCP Location (please circle): MetroHealth UH/RBC Cleveland Clinic Other: _____

Legal Guardian Information:

Guardian's Last Name: _____ First Name: _____

Guardian's Date of Birth: _____ Guardian's Social Security Number: _____

Employer: _____ Employer Phone: _____

Phone 1: _____ Phone 2: _____

Please circle preferred contact phone number: Phone 1 or Phone 2

Insurance Information: (Please fill in all information so that we don't have to copy your card)

Child/Teen has insurance (please circle): Yes or No

Insurance Name: _____ Subscriber's Name: _____

Group Number: _____ Subscriber ID: _____

Emergency Contact Information:

Name: _____ Relationship: _____

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

Please list any people that you authorize to have access to your child's health information:

Name: _____ Phone: _____ Relationship to Child: _____

Student Health History

Student Name: _____ Date of Birth: _____

Patient's Medical History (please circle all that apply)

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

Other: _____

Current Medications

Does your child take any medicine? Yes/No,

If Yes, please list all medicines, including how much and how often:

_____

Will they be taking any medicine at school? _____

Allergies: Food Y /N **Medicine? Y / N** **Other? Y/ N**

If yes, please list ALL allergies_____
If allergies, do they need an EpiPen**? Yes / No**

Inhaler use: Y/ N Name of inhaler(s)_____

Nebulizer Use Y /N Name of medicine(s)_____

Use at school? Y/ N

Past Hospital Stays Y / N Past Surgery? Y / N How many ER visits in past year?_____

Why_____

_____

Family History (please circle all that apply) and list who has the problem next to it
(**biologic** parents, grandparents, brothers, sisters, living or deceased)

Anemia	AIDS/ HIV	High Blood	Heart Disease
Diabetes	High Cholesterol	Pressure	Sickle Cell
Headaches	Arthritis	Asthma	Drug Abuse
SIDS/ Sudden	Cancer	Stroke	Tuberculosis/ TB
Infant Death		Alcoholism	Seizures

Social History
Exposed to tobacco smoke at home? Y / N

Who lives in your home? _____

School: _____Student Name:_____ Date of Birth:_____

THE METROHEALTH SYSTEM
AND
NEIGHBORHOOD FAMILY PRACTICE

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 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 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 physician or healthcare provider through MetroHealth's or Neighborhood Family Practice'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 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 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 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]

[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.

4. Release of PHI

I authorize MetroHealth and/or Neighborhood Family Practice 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 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 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. I understand that I may terminate this authorization in writing at any time, prior to the release of my Child's PHI.

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.

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.

The MetroHealth System
2500 MetroHealth Drive
Cleveland, OH 44109-1998

Encounter Label

Medical Record Number _____

Patient Name _____

Acknowledgement of Receipt of the Notice of Privacy Practices

Acknowledgement of Receipt of Privacy Practices: I, the undersigned, acknowledge that I have received and have been given an opportunity to review the Notice of Privacy Practices. I understand that I will be given additional copies of the Notice of Privacy Practices anytime at my request.

_____

Signature

_____

Print Name

_____

Authority, if Personal Representative

_____

Date

_____

_____

_____

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