STUDENT GENERAL CONSENT

These forms are being requested by Health Services, Inc. The Montgomery Public School System does not condone or endorse the solicitation of any information that may be requested.

I understand that necessary and advisable health care services will be provided by qualified health care professionals and that my son/daughter is eligible to receive these services.

I understand that the following services will be available:
- Assessment and treatment for minor injuries.
- Assessment and treatment for minor illnesses (including providing appropriate over-the-counter medications such as Tylenol or Advil for simple concerns such as headache, cramps, etc.)
- Physical exams for school, sports and employment.
- Collaboration with the school nurse in the care of certain chronic conditions, such as asthma
- Follow-up examinations as requested by family physician or health care provider.
- Routine lab tests, as deemed medically necessary.
- Immunizations.
- Prescriptions.
- Dental screenings, examinations, sealants, and dental referrals.
- Visual examinations and referrals.
- Behavioral health services, such as individual and group counseling.
- Counseling for students regarding nutrition, personal hygiene, family and relationship issues, human growth and development and other health related issues.

I understand that all services are confidential. I understand that only Health Services, Inc. will have access to the student’s medical chart, and that medical records or information from medical records cannot be released without the written consent of the patient and/or parent except that Health Services, Inc. is required to make such records available upon request from the Medicaid program or other payer in order to document the extent of services billed. Furthermore, I understand that information obtained by health professionals at Health Services, Inc. will not routinely be shared with the principal, guidance counselors, teachers or other staff. I understand that Health Services, Inc. will collaborate with the school nurse, to receive health information detrimental to the health of the child (for example, medication allergies and significant past medical history).

I understand that Health Services, Inc. will bill Medicaid and/or any other insurance carrier providing coverage for the student.

I understand that my consent is required by Health Services, Inc. before my child can receive services. I understand and have been provided with a copy of the Health Services, Inc. Notice of Privacy Practices that provides a more complete description of the uses and disclosures of the student’s health information.

In order for my child to receive health care services at Health Services, Inc. School Based Health Center: (1) I authorize the nurse, or other designated health care professionals, to provide necessary and/or advisable assessment and treatment for the above named student. (2) I give permission for necessary medical tests and treatments. (3) I further release and hold harmless the Montgomery Public Schools...
Board of Directors and do give, grant and release from any and all liability, costs or loss which my child may sustain or incur now, or at any time in the future or as a direct or indirect result of any treatment, consultation or other action or inaction by Health Services, Inc.

☐ I hereby give permission for my child ______________ to become a patient of Health Services, Inc. (HSI) or be treated in the HSI School Based Health Center.

☐ I DO NOT give permission for my child to become a patient of Health Services, Inc. (HSI) or be treated in the HSI School Based Health Center.

Parents/Guardian:

__________________________________________________   ________________   ________________

Signature                                                                                      Date                  Date of Birth

☐ Verbal Consent obtained by __________________________

(Signature)

Witnessed by: __________________________

(Signature)
Please circle one of the following HSI School Based Health Centers:

- Bellingrath SBHC
- Highland Gardens SBHC
- Davis SBHC
- Chisholm SBHC

Child’s Full Name: ________________________________ DOB: __________ Sex: ________
First          Middle          Last
Mailing Address: __________________________________ City/State: ________________ Zip: __________
Home Phone: (________) ____________________________ Social Sec. #: ______________________

Ethnicity (Enia): ☐ Hispanic or Latino Race (Raza) ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Asian
☐ Black/African American ☐ White ☐ More than one race

Parent or Legal Guardian: ________________________________ DOB: ______________________
Name of Employer: ________________________________ Work Number: ______________________
Cell Phone Number: ________________________________ Email address: ______________________

Emergency Contact: ________________________________ DOB: ______________________
Address: ______________________________________ Contact Number ______________________

May we leave messages via phone and/or email? Phone ☐ Yes ☐ No   Email ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated
Ethnicity (Enia): ☐ Hispanic or Latino Race (Raza) ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Asian
☐ Black/African American ☐ White ☐ More than one race

Homeless Status (if applicable): ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional ☐ Other____________________

Insurance Information:
Primary Insurance: __________________________________________________________
Name of Policyholder: ________________________________ Relationship to patient/child________
Policy Holder Date of Birth: __________________________ Social Sec. #: ______________________
Contact/Member ID#: ________________________________ Group#: __________________________

Secondary Insurance: __________________________________________________________
Name of Policyholder: ________________________________ Relationship to patient/child________
Policy Holder Date of Birth: __________________________ Social Sec. #: ______________________
Contract/Member ID#: ________________________________ Group#: __________________________

Please place a check mark if you do not have insurance to cover this student: ☐
I hereby understand that any amount not paid by the insurance company, that I will be
Initial responsible for full payment.
Financial Verification Self-Pay  □ I DO NOT wish to provide income documentation and understand that I will not receive discounts.

(Patient+ spouse+ dependents)  Source of Income (Employer, SSI, Food Stamps, etc.)  Income Amount

1.  $  
2.  $  
3.  $  
4.  $  
5.  $  

Expiration Date: ________________  Total Household Income: $_______________

I hereby agree that the information given relative to my legal residence and financial condition as recorded in my presence upon this form is true and that it may at any time be verified by an authorized investigator.

______ I have received a copy of the income information sheet and its requirement to return financial proof in order to qualify for sliding fee discounts and I assume responsibility for all fees for service for myself and those for whom I am responsible.

______ I acknowledge that I have received a copy of the Patient Bill of Rights, Notice of Privacy Practices, Primary Care Medical Home Information Sheet and Advanced Directive Sheet.

______ I DO NOT want my medical or financial information discussed without my approval.

Please provide the list of names and date of birth for the individuals you wish to be given any, and all of your medical or financial information or who may accompany my child/children for treatment

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Patient_____________________________________________  Date: _______________________

Signature of Policyholder: _________________________________________  Date: _______________________

Signature of Claimant: ___________________________________________  Date: _______________________

Witness: _________________________________________________________  Date: _______________________

(HSI Patient Representative)
Please complete this information to register your child with the Health Services, Inc. School Based Health Center.

1. Child’s Name: _____________________________  DOB: ____________ Age: ____________
2. Grade in school (circle one): Preschool or Kindergarten
   1    2    3    4    5    6    7    8    9    10    11    12
3. Where do you take your child when he or she is ill? (Check the ones that apply)
   Private Doctor?    Name of Doctor: _______________________________
   Hospital Emergency Room?    Name of Hospital: ______________________________
   Other?    Please explain: ________________________________________
4. Has your child seen a doctor in the last year?    Yes    No
   Why? _________________________________________________________________________
5. Has your child used a Hospital Emergency Room in the last year?    Yes    No
   Why? _________________________________________________________________________
6. Was your child in the hospital overnight in the last year?    Yes    No
   Why? _________________________________________________________________________
7. Does your child have any of these problems?
   □ Asthma (trouble breathing)    □ Frequent ear infections    □ Problems sleeping
   □ Stomach problems    □ Frequent headaches    □ Skin problems
   □ Hearing problems    □ Frequent colds bad enough to miss school
   □ Other: (explain) _____________________________________________________________
8. Is your child allergic to any foods?    Yes    No
   If yes, please explain: ___________________________________________________________
9. Has your child ever had an allergic reaction to medication?    Yes    No
   If yes, please explain: ___________________________________________________________
10. List any prescription medications your child presently takes.
    ______________________________________________________________________________
    ______________________________________________________________________________
    ______________________________________________________________________________
    ______________________________________________________________________________
11. Has your child had chicken pox?    Yes    No
12. Is your child currently seeing a specialist?    Yes    No
13. If yes, give specialist’s name: ___________________________________________________