School Year 2024-2025

School-Based Health Consent for Sterling Health Care, Inc. Services.

Medical providers (Sterling Health Care, Inc.) will offer health services including, but not limited to, acute care, preventive services, school physicals, medications for minor illnesses, and emergency treatment as needed. Basic laboratory testing will be provided at the School Clinic when requested by a parent or if a child comes to the clinic with symptoms indicating the need for a lab test, or if it is a required part of the physical examination. Please review this form carefully and complete all requested information. **Providers cannot/will not provide services to your child without this signed consent**. This consent does not cover immunizations. You must contact the Clinic at school, or the Providers will contact you to obtain separate consent for that service. The parent or guardian may withdraw consent at any time by informing the provider in writing.

Student's School:_____

Last Name:_____ **First Name:**_____ **Middle Name:** _____

Gender: M/F **SSN:**_____ **Birth Date:**_____ **Nickname:**_____

Race: ☐White ☐ Black/African American ☐ Asian ☐American Indian/Alaskan Native ☐ Native Hawaiian ☐Other

Ethnicity: ☐Hispanic/Latino ☐Non Hispano/Non Latino **Primary Language:**_____ **Interpreter Needed?** ☐ Yes ☐ No

Address:_____

Contact Phone: _____ **Work Phone:** _____ **Email Address:**_____
Preferred Communication: Phone/Email

In case of emergency, please contact:

Name of Mother/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:**_____

Name of Father/Legal Guardian:_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Student's Doctor: _____ **Student's Dentist:**_____ **Pharmacy:**_____

INSURANCE INFORMATION
Do you have insurance? ☐ Yes ☐ No **Primary Insurance:** _____ **ID#**_____ **GROUP#**_____

Secondary Insurance: _____**ID#**_____ **GROUP#**_____

Policy Holder Name:_____ **Policy Holder Date of Birth:**_____**Policy Holder Gender:** M/F

Policy Holder Phone:_____ **Policy Holder SSN:** _____

Policy Holder Address if different from Patient:_____

This information is necessary for the student's health record to be complete, but will ONLY be billed if services are provided by the Nurse Practitioner or PA. School nurse visits are not billed to insurance.

Student Medical History:
The following information will help the School Nurse/Nurse Practitioner/PA make an accurate assessment of your child in the event of illness or emergency.

ALLERGIES: List all medications, vaccines, foods or any other allergies: _____

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

****You will be asked to complete a separate Medication Consent form if you would like the School Nurse to administer medication at school.**

Any hospitalizations? ☐ Yes ☐No

Reason for hospitalization	Hospitalization date	Facility Where Hospitalized

Any surgeries? ☐Yes ☐No

Type of surgery	Procedure date	Facility where the procedure was performed

HAS YOUR CHILD EVER BEEN TREATED BY ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Allergies			Heart Murmur			Chicken Pox		
Asthma			Wheezing			Urinary Tract Infection		
Eczema			Pneumonia			Acne		
Seizures			Ear Infections			Serious Injury or Concussion		
Developmental and/or speech problems						ADHD/ADD		
Diabetes						Other		
If Other Please Explain:								

FAMILY HISTORY: Do any family members have any of the following conditions?

Condition	Relative	Condition	Relative	Condition	Relative
Heart Attack	Age:	Pancreatic Cancer		Migraine	
High Blood Pressure		Any Other Cancer		Seizures	
Congestive Heart Failure		Colitis		Diabetes	
Rheumatic Heart Disease		Crohn's Disease		Goiter	
Congenital Heart Disease		Colon Polyps		Bleeding Tendency	
Breast Cancer	Age:	Hepatitis		Suicide	
Colon Cancer	Age:	Stomach Ulcer		Mental Illness	
Leukemia		Kidney Disease		Tuberculosis	
Melanoma (skin cancer)		Stroke		Other	
Ovarian Cancer		Asthma		Drug or Alcohol Abuse	

When was the last time your child was seen by a doctor?
Doctor's Name*:*_____ Reason:_____ Date*:*_____

Is your child up to date on immunizations? ☐Yes ☐No Where is the child's immunization record on file?_____
☐ Yes, I give permission for the school nurse to provide a copy of the immunization record
Do you have concerns about your child's health? ☐Yes ☐No Does your child smoke and/or use tobacco products? ☐Yes ☐No
Does your child drink alcohol? ☐Yes ☐ No Is your child exposed to secondhand smoke? ☐Yes ☐No

INCOME: **Note: Sterling Health Care Center, Inc. is dedicated to providing health care to the community. We rely on grant funds to support our school-based health programs. By providing the requested income information, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!

Household Size: _____ Family Income:_____
*

Sterling Health Care, Inc. Center School-Based Health Assignment of Benefits/Consent for Treatment

I consent to routine testing, procedures that may be deemed necessary for the treatment of my child's condition by members of the medical staff at Sterling Health Care, Inc. Center. Consent is hereby granted for such visits to the school nurse's office for the purposes of examination, treatment and procedures provided by a qualified Nurse Practitioner or PA. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party accepting the assignment. I authorize payment of medical benefits to the provider for services provided by Sterling Health Care, Inc. Center. I understand that I may be charged separately for services provided by clinic providers for treatment-related services. I hereby authorize payment directly to the professional providing these services that would otherwise be payable to me. *Services performed by the school nurse are not billed.

Authorize the release of medical information

I hereby authorize the release of medical information as necessary for the settlement of this claim. Unless otherwise indicated, this authorization extends to psychiatric, alcohol or drug, and HIV-related diagnostic information, if any, that may be contained in the clinic records. I understand that I have the authority to release the above referenced medical records as well as release of records to my child's primary care provider. I further release Sterling Health Care, Inc. Center and any related corporation or affiliate from any liability arising from the release of these medical records and agree to identify and hold them harmless from any such liability. This constitutes permission to disclose medical information related to sexually transmitted diseases, if applicable, to a Third Party Payor pursuant to KRS 214.420. I have read the above and understand that the above articles apply to me. I verify that I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

_____ _____
Date Signature of parent/legal guardian (REQUIRED)

_____ _____
Best phone number to contact you Email to link you to Patient Portal for child's health record

_____ _____
Date Signature of Witness

If the parent/legal guardian signs with (X) or the authorized person provides verbal consent, two signatures with names, addresses and telephone numbers must be entered below.

_____
Date Phone Number Witness Name Address

_____
Date Phone Number Witness Name Address