

Consent for School Health Services

Madison County Health Department

CHILD / STUDENT INFORMATION

Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Team \_\_\_\_\_

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

(Please give child's complete legal name)

Child's Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Race \_\_\_\_\_ Male Female How many people live in the home? \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Father \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Emergency Contact Person OTHER than guardian or parent \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is your child ELIGIBLE for free or reduced lunch? Yes / No / Don't know

Has your child EVER attended a Madison County School? Yes / No Name of School \_\_\_\_\_

My child HAS the following life threatening condition that requires EMERGENCY treatment or medications to be given at school.

DIABETES ASTHMA SEIZURES SEVERE ALLERGY OTHER

Child's Medical History

1) Significant medical history: \_\_\_\_\_

2) Medications taken on a regular basis \_\_\_\_\_

3) Allergy to MEDICATIONS? If YES, please LIST: \_\_\_\_\_

EXPLAIN REACTION: \_\_\_\_\_

4) Allergies to: Peanuts Bee/Wasp Stings EXPLAIN REACTION: \_\_\_\_\_

OTHER: \_\_\_\_\_

5) My child has had: Chicken pox vaccination: Yes No Chicken pox disease: Yes No

Child's Medical Insurance

Does your child have a KY Medicaid Card Yes No Number \_\_\_\_\_

Does your child have a K-CHIP Card Yes No Number \_\_\_\_\_

Does child have other medical insurance? Yes No Name of Company \_\_\_\_\_

Does it cover Immunizations? Yes No Don't know

Child's Health Care Provider \_\_\_\_\_ Child's Dentist \_\_\_\_\_

Does anyone smoke in your child's home? Yes No

Consent for Health Services/Assignment of Benefits

I consent to care which may include screening, exams, assessments, lab tests, treatment, first aid, over-the-counter medicine, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to release medical /dental information about my child to his/her primary care or dental provider. I also understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or K-CHIP, I also authorize the school clinic to release this information to Medicaid/K-CHIP so that the Medicaid/K-CHIP can be billed for visits to the school clinic. I also understand by signing this consent, I acknowledge that I have received a copy of the Madison County Health Department's Privacy Notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent /legal guardian / emancipated student)

(EXPIRES ONE YEAR AFTER DATE SIGNED) MCHD 2 (6/09)