Indian Health Center
CONSENT FORM 2010 - 2011
6100 Sissonville Drive, Sissonville WV 25320
Phone: 304-984-1361 Fax: 304-984-0362
Follow us on Twitter @IndianHC

STUDENT INFORMATION

Student Name: ____________________ Student's SS#: ____________________

Address: ____________________ Date of Birth: ____________
City: ____________________ State: ______ Zip: ______

Student's Cell: ____________________ Grade: ______

Gender: ☐ Female ☐ Male

Race: ☐ White ☐ Black ☐ Hispanic ☐ Other __________

PARENT/GUARDIAN INFORMATION

Parent/Guardian: ____________ Phone (1) ________ (2) ________ (3) ________
Parent/Guardian: ____________ Phone (1) ________ (2) ________ (3) ________
Alternate: ____________ Phone (1) ________ (2) ________ (3) ________
Alternate: ____________ Phone (1) ________ (2) ________ (3) ________
Where can you be reached during school hours? ____________________

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at Indian SBHC as outlined in the fact sheet. I understand that this consent form will be good until my child leaves/graduates school or until I provide the staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form I am giving the SBHC, school nurse and my child's regular doctor (if applicable) permission to communicate and share medication information regarding my child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. The heath center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents, and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

____________________ ____________________
Signature of Parent/Legal Guardian Date

Must have signature on both pages for consent to be valid.

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HEALTH INFORMATION

1. List any medication allergies ______________________

2. List all current medications ______________________

3.Family Physician/Pediatrician: ______________ Family Dentist: ______________

☐ **No current family physician/pediatrician**

4. Date of last complete check-up ______________________
5. Please initial if you would like your child to have a physical exam completed at the SBHC. __________
6. Pharmacy of choice? Location:

INSURANCE INFORMATION - Check all that apply and send a copy of your insurance card (if possible)

☐ **Insurance** Company: ______________ Address: ______________

ID # ______________ Group #: ______________
Policy holder name: ______________ Date of Birth: ______________
Place of Employment: ______________
Policy holder SS#: ______________

☐ **Medicaid** Please check one

☐ Unisys ☐ Unicare ☐ Carelink
ID # ______________ Group # ______________

☐ **WV Chip** ID # ______________

☐ **No health insurance. Please see attached information on CHIP and Patient Assistance**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Please note that there is an attached copy of HIPAA to this consent form, for the parent/guardian of the student receiving medical or mental health counseling services at Indian Health Center. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services.

I certify that a copy of the Health Insurance Portability and Accountability Act of 1996 was provided with the Indian Health Center's consent form, to the parent/guardian of ______________ on this date.
(Student Name)

______________________ ______________________
Signature of Parent/Guardian Date

______________________ ______________________
Signature of Indian Health Center Staff Date

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Cabin Creek HEALTH SYSTEMS

FERPA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICALPROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____

Last First MI Date of Birth

I, the undersigned, do hereby authorize Indian Health Center to provide health information from the above-named child's medical record to and from: Sissonville High School
Address 6100 Sissonville Drive, Sissonville, WV 25320
Sissonville High School Contact Person: Brenda Crowder, RN
Phone #: 304-348-1954
The disclosure of health information is required for the following purpose: Vaccine information
Requested information shall be limited to the following: ☐ All minimum necessary health information; or
☐ Disease-specific information

DURATION:

This authorization shall become effective immediately and shall remain in effect until August 1, 2012 or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

______________________ ______________________ ____________
Printed Name Signature Date

______________________________ ______________________________
Relationship to Patient/Student Area Code and Telephone Number

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