Please Return to School

Consent for Public Health Nursing/School Nursing Services

Three Rivers District Health Department

CHILD / STUDENT INFORMATION

Teacher_____ Grade_____

Child's Last Name_____First Name_____MI_____

(Please give child's complete legal name)

Child's Social Security #_____**Birth Date**_____

Race (check one or more): ___(W) White ___ (B) Black or African American ___(N) American Indian or Native Alaskan ___(A) Asian ___(H) Native Hawaiian or Other Pacific Islander

Ethnicity (check one): ___(Y) Hispanic or Latino ___ (N) Not Hispanic or Latino

Sex: _____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

Last School Attended_____

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) My child has had: Chicken pox disease: Yes / No Chicken pox vaccination: Yes / No
4) Allergy to MEDICATIONS _____
5) Other Allergies (Peanuts, Bee or Wasp Stings etc.) PLEASE LIST:_____
6.) Requires a special diet?_____

Child's Medical Insurance

Does your child have a KY Medicaid Card Yes / No Number_____MCO #_____
MCO Carrier? __Ky Spirit __Well Care __Coventry Care
Does your child have a KCHIP Card Yes / No Number_____
Does your child have other medical insurance? Yes / No Name of Company_____
Does it cover Immunizations? Yes / No / Don't know Insurance #_____Group #_____
Card Holder_____Co-Pay amt.$_____

Child's Health Care Provider_____**Child's** Dentist_____

Does anyone smoke in your child's home? Yes / No *** Please attach a copy of the child's Medicaid and MCO card**

Consent for Health Services/Assignment of Benefits

I consent to care which may include screenings, assessments, treatment, first aid, over-the-counter medicine, and any other health service given to me/my child by staff of this local health department satallite/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/receive medical /dental information about my child to/from 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. I request that payment of authorized medical benefits be made to Three Rivers District Health Department on my child's behalf for services received. I also authorize the health department to release medical information about my child to Medicaid/KCHIP, Health Insurance or other third party payors to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Three Rivers District Health Department's Privacy Notice.

EXPIRES ONE YEAR AFTER DATE SIGNED

X_____

(Signature of parent /legal guardian / emancipated student) (Date signed) **TRDHD CH5-S (05/12)**

SEE BACK→