WHITEFOORD

PEDIATRIC CONSENT FORM

I understand that Whitefoord Inc. Health Centers and School Based Health Centers can provide comprehensive health services to my child. I also understand that I have the right to withdraw this consent at any time upon written notice to the medical director.

I authorize (check all services for which you consent):

☐Release of information from the child's medical record whenever necessary for payment, continued care or treatment, and healthcare operations.

☐I further give consent for staff to examine the child's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.

☐For my child to receive medical care including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, referrals, and other minor office procedures.

☐Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian

☐For my child to receive dental care. This includes periodic dental examinations for my child, which may include screenings, photographs, radiographs and any other acceptable methods for the dental evaluation and management of the child's dental health.

☐For my child to receive behavioral health and counseling services, including one-on-one counseling, community resource referrals and outreach and coordination of outside resources.

☐Participation in health education sponsored/coordinated by Whitefoord Inc.

☐That in the case of a medical emergency, I give permission to Whitefoord Health Centers to call emergency transport for my child.

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know" basis to the Whitefoord Health and School Based Health Center staff members, and also for Whitefoord Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following: immunization records, class schedules, parental contact, address, phone number, medical/behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from Whitefoord Health Centers may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed below to release information to the Health Center staff members as needed. I hereby authorize the Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize Whitefoord Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, Health Center staff members will use and share my Personal Health Information (PHI) for: treatment of my child's health condition, maintaining the continuity of my child's care and payment for health services provided to my child, and routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services.

I have read and understand the above information and give permission for the child's care as described. I understand that I have the right to opt the child out of any medical testing or treatment. This consent will last for three years or the duration of the child's time at their current school housing a Whitefoord School Based Health Center location.

Name of Parent or Legal Guardian (please print):	Name of Child (please print):
Signature of Parent or Legal Guardian:	Relationship to Child: Date:

Rev. Aug, 2021

PLEASE WRITE CLEARLY

School Based Health Center Consent

School: _____
Grade: _____
Homeroom Teacher: _____

PATIENT INFORMATION

Name:_____ **Date of Birth:** _____
Address: _____
Home Phone: _____ **Email address**: _____
Parent (please circle) Mom Dad Other: _____
Child lives with (please circle) Mom Dad Other:_____
Emergency Contact: _____
Phone: _____ Cell Landline (please circle)
If unavailable, can Whitefoord discuss your personal health information with anyone else?
Name & Relationship to child: _____
Phone Number: _____

Insurance Information:

Insurance carrier name: _____
ID/Member Number: _____Group Number: _____
Policy Holder & Date of Birth: _____

The following is required because we receive Federal funding for providing services at a discount. This information is for statistical purposes and will not be disclosed.

Total household income: _____
Please circle: Hourly Weekly Monthly Yearly
Number of people in the household: _____
If there is no insurance coverage, would you be interested in discounts based on a sliding scale? Yes No
Would you like someone to contact you about applying for the discount? Yes No
Services requested (please circle): Medical Dental Counseling or Behavioral Health Services
Patient Gender Identity (please circle): Male Female
Patient Race (please circle): American Indian - Alaskan Native – Asian - Native American – Black - White
Ethnicity (please circle): Hispanic/Latino - Not Hispanic/Latino - Unknown

Patient Medical History:

Allergies: _____
Please list any surgeries: _____

Medical conditions:

Please circle answer
Asthma: Yes No
Diabetes Yes No
Other Yes No **Please explain if yes**: _____
Recent ER Visit (please circle): Yes No
If yes, please explain:_____
Reason for Visit: _____
Facility: _____
Current Medications: _____
Please include doses, mgs, and how often taken
Do you have another Primary Care Provider? Yes No
Provider's Name: _____
Provider's Phone Number: _____

Parent Signature: _____ **Date:** _____

Rev. Aug, 2021