Revised 6/26/18

iFM Community Medicine School Health Program
Parental Consent Form (Grades K-12)
St. Louis County Special School District

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____
Student's First Name: _____
Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address: _____
_____
_____ _____ _____
City State Zip Code

Who is the student's regular doctor?
Name: _____
Telephone: _____
Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, If Applicable
Last Name: _____ First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____

INSURANCE INFORMATION

Does your child have Straight Medicaid?
❑ No ❑ Yes: Medicaid ID # _____

Does your child have MoHealthnet?
❑ No ❑ Yes: ID/DCN # _____

Which Plan?
_____

Does your child have other insurance?
❑ No ❑ Yes:

Insurance Company: _____

Group Number: _____

ID Number: _____-

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the IFM COMMUNITY MEDICINE School-Based Health Center.
NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention for students over 13 years of age, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

Special School District
Clinic

North Tech Nurse's Office
1700 Derhake Rd.

Mondays
(alternating mornings and afternoons)

Call Nurse Karen Kitchen for specifics
314.989.7600

Stop by and see us for...

- Physicals
- Screenings
- Sick care
- Assistance with chronic care management

Available to students and staff of SSD
at no out of pocket cost

Chontay McKay, APRN, FNP-C

iFM Community Medicine
Individual. Familiar. Mobile.

partners for student success
SSD

About iFM Community Medicine

iFM Community Medicine is a 501(c)(3) non-profit health care organization with 20 partner locations throughout the St. Louis area.

Our Mission is "Strengthening underserved communities, one patient at a time."

iFM partners with SSD, other school districts, and non-profit organizations to bring quality health care services to their students and clients "within their walls" to reduce barriers to accessing care.

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iFM Community Medicine School Health Program
School Parental Consent Form
St. Louis County Special School District

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of IFM COMMUNITY MEDICINE as part of the school health program approved by the St. Louis County Special School District. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and *required and recommended immunizations.*
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the school-based health center.
8. Vaccines required by the State for school attendance.

Time Period During Which Healthcare Services are Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the St. Louis County Special School District.

HIPAA Authorization for Use or Sharing of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your signature may be required in certain circumstances before your health information may be used or shared.

This authorization permits iFM Community Medicine to release certain medical information as stated below. You may refuse to sign this Authorization. You will not be refused health care treatment if you do not sign this Authorization. You may sign this form and later change your mind by sending a letter to iFM Community Medicine. You can request a copy of this form.

iFM Community Medicine may use or disclose my medical information regarding treatment or payment for services. iFM Community Medicine may share information with insurance companies for payment and your primary care provider (if applicable) and others for treatment.

I understand that iFM Community Medicine will make a good faith effort to release only the minimum amount of necessary information needed to carry this out.

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT