BAPTIST HEALTH®

FOUR RIVERS BEHAVIORAL HEALTH 50 Providing Mindful Care for more than fifty years

CONSENT FOR SCHOOL-BASED HEALTH CENTER

☐ Yes – I consent for my minor child to receive health care services provided by Baptist Health and Four Rivers Behavioral Health in the school-based health center as determined by the school-based health center's staff.

• This consent will remain in effect until the end of the existing school year in which this consent was signed, or until I revoke this consent in writing and provide the revocation to the staff of Baptist Health and Four Rivers Behavioral Health.

• I affirm that I have the right to consent as the parent or legal guardian of the minor child as listed below. I understand that it is my responsibility to notify Baptist Health and Four Rivers Behavioral Health about changes in my legal guardianship.

• I understand that Baptist Health may notify me if my minor child received care in the school-based health center, except in the event my minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky Revised Statute 214.185.

• I understand that Four Rivers Behavioral Health may notify me if my minor child received care in the school-based health center, except in the event my minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky Revised Statute 214.185.

• I authorize Baptist Health and Four Rivers Behavioral Health and each of their staff to communicate with my minor child's health care providers about health care services rendered by Baptist Health and Four Rivers Behavioral Health at the school-based health center.

• I authorize Baptist Health and Four Rivers Behavioral Health to bill my health insurance provider for health care services rendered at the school-based health center.

Student's Name_____ Date of Birth_____ SS#_____
Last *First* *Middle* *(mm/dd/yy)*

School_____ Grade_____

Home Address _____ City_____ State_____ Zip_____

Names of Parents/Guardians_____

Subscriber's Name_____ Date of Birth_____
Last *First* *Middle* *(mm/dd/yy)*

SS# _____ Subscriber's Employer_____

Student's Allergies *(including medication allergies)*_____

Pharmacy of Choice_____ Pharmacy Phone #_____

Emergency Contact_____ Relationship to Student_____ Phone #_____

Name of Child's Doctor/Office_____ Phone #_____

Doctor/Office Address_____

Name of Health Insurance or HMO_____

Medical Care Number_____ *(The school -based health center will need a copy of your card, front and back)*

Confidentiality: The information in my minor child's medical record is confidential and, unless as authorized by law, will not be released to any unauthorized person or agency without my authorization. However, I understand that it may be necessary for staff of the school-based health center to confer among themselves and the school's health professional about treatment related to my minor child. I understand that, as a courtesy, medical records of any treatment provided to my minor child at the school-based health center will be forwarded to my minor child's family doctor.

Signature of Parent or Legal Guardian_____

Date_____