CONSENT FOR SCHOOL-BASED HEALTH CENTER

__Yes- I consent for my minor child to receive health care services by Baptist Health in the school-based health center as determined by the school-based health center's staff. I further consent for my child to receive medical care through telehealth and/ or remote patient monitoring, and to the interpretation of diagnostic studies from an off-site location using telehealth technologies.

- 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.
- 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 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 Statue 214.185.
- I authorize Baptist Health and each of their staff to communicate with my minor child's healthcare providers about healthcare services rendered by Baptist Health at the school-based health center.
- I authorize Baptist Health to bill my health insurance provider for healthcare services rendered at the school-based health center.

Student's Name_________________________________ Date of Birth___________ SS#________________

School____ Grade______________________________

Home Address_________________________________ City____________ State___________ Zip__________

Name of Parents/Guardians___________________________ Parents/Guardians Phone Number________________

Policy Holder's Name____________________ Policy Holder's Date of Birth_________________________

Policy Holder's Address__________________________ City_____________ State___________ Zip__________

Policy Holder's SS#________________________ Policy Holder's Employer_____________________

Name of Health Insurance_______________________ Policy #_______________ Group _____________

Student's Allergies (including medication allergies) ____

Pharmacy of Choice_________________________________ Pharmacy Phone#______________________

Emergency Contact________________________ Relationship to Student_____________ Phone#______________

Name of Student's Doctor/Office_______________________________ Phone#__________________

(The school-based health center will need a copy of your insurance card, front and back)

Confidentiality: The information in my minor child's medical record is confidential and, unless 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_________________________