SIMPSON COUNTY BOARD OF EDUCATION

430 SOUTH COLLEGE STREET • Telephone (270) 586-8877 • Fax (270) 586-2011
FRANKLIN, KENTUCKY 42134

TIM SCHLOSSER
SUPERINTENDENT

Dear FS parents and guardians,

I hope you had a great fall break and good first week back to school. I am writing to inform you of a change in the nursing program in the Simpson Co. School district. In August the Barren River Health Department informed us that they no longer would be providing school nurses for the district effective December 31, 2019.

At that time, SCS began to search for a new provider of the school nurse program. In September, the board of education accepted a bid from The Medical Center to provide school nurses in all 5 of our schools. On November 1, 2019 that contract will begin in each of our schools.

In order to make this transition there is some paperwork that must be completed. There are 2 forms that must be completed for your child to receive services from the school nurse. The first form is for the health department to be able to transfer any files that they have on your student to The Medical Center. The other form is the consent form to be seen by the school nurse. I apologize for the inconvenience in having to fill out these forms, but we look forward to the partnership we have developed with The Medical Center moving forward.

We also have a nurse practitioner provided by The Medical Center at the middle school for any medical needs that you may have. If you have any questions please contact the school that you student attends.

Sincerely,

Tim Schlosser

Superintendent

SIMPSON COUNTY PROVIDES EQUAL EDUCATIONAL AND EMPLOYMENT OPPORTUNITIES

Medical Center
Primary Care
Franklin

MEDICAL INFORMATION RELEASE AUTHORIZATION

I, ______________________ (Parent/Guardian Name), give authorization for the **Barren River District Health Department**, 1109 State Street, Bowling Green, KY 42101 to release information from the Simpson County School student health file on:

Student Name: ___________________________ Date of Birth: ______________________

Social Security Number: ____________________ School Attending: ____________________

To release the following records to **Med Center Health Primary Care Franklin,** 1020 South Main Street, Franklin, KY 42104:

- Medication Administration Record 2019-2020 school year
- Controlled Substance/Uncontrolled Substance Logs 2019-2020 school year
- Physician Orders 2019-2020 school year
- Authorization Forms 2019-2020 school year
- Hearing and Vision Screenings each year performed
- Immunization Record (current)
- Health Questionnaire 2019-2020 school year
- Nurse Notes for 2018-2019 and 2019-2020 school years
- Nurse Visits for 2018-2019 and 2019-2020 school years
- Permission form for prescribed medication 2019-2020 school year

The reason for the release is due to Med Center Health Primary Care Franklin will replace Barren River District Health Department in providing nurses for the school health program at Simpson County Schools beginning November 1, 2019.

I understand that this authorization is valid only for a maximum of 180 days from the date below, and it covers only treatment prior to November 1, 2019.

This information may be released by facsimile machine if request warrants. Commonwealth Health Corporation and its subsidiaries are hereby released from any liability and the undersigned will hold Commonwealth Health Corporation harmless for complying with this authorization. A Photostat copy of this authorization is acceptable and will be treated as original.

The undersigned acknowledges that the provision of free medical records by any healthcare provider who receives this release shall fulfill that healthcare provider's obligation to provide

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one free copy of the medical records, and that any future report request for medical records from the healthcare provider may result in a copying fee up to one dollar per page.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Revocation date: ________________ Patient/Legal Representative: ____________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information comes with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Parent/Legal Representative Signature: X________________________ Date: ______________

Relationship to Student: ___________________________

~~Please mail or fax the completed authorization form to:~~

~~Med Center Primary Care Franklin~~
~~1020 South Main Street~~
~~Franklin, KY 42134~~
~~Fax: 270-586-0255~~

* PLEASE RETURN TO YOUR SCHOOL *

1020 South Main Street • Franklin, Kentucky 42134
270.586.5888 • Fax 270.586.0255 • MedicalCenterPrimaryCare.com

School Health Services Consent

HOMEROOM TEACHER:____________________ GRADE:_______ LANGUAGE(S) SPOKEN AT HOME:____________________________

CHILD'S LEGAL NAME_______________________ BIRTHDATE:_______________ RACE:_________ MALE___ FEMALE___

CHILD'S SOCIAL SECURITY NUMBER:____________________________________

ADDRESS: ____ CITY/STATE/ZIP ____________________________________

CHILD'S TRANSPORTATION: _____ BUS RIDER _____ CAR RIDER _____ WALKER _____ ATTENDS AFTER SCHOOL PROGRAM AT SCHOOL

PARENT/GUARDIAN NAME:____________________________________ RELATIONSHIP TO CHILD:______________________

HOME PHONE #____________________ CELL PHONE #____________________ WORK PHONE# ______________________

PARENT/GUARDIAN NAME:____________________________________ RELATIONSHIP TO CHILD:______________________

HOME PHONE #____________________ CELL PHONE #____________________ WORK PHONE# ______________________

EMERGENCY CONTACT (other than parent):_______________________RELATIONSHIP TO CHILD:______________________

HOME PHONE #____________________ CELL PHONE #____________________ WORK PHONE# ______________________

MEDICATION ALLERGIES:____

_____ RED DYE ALLERGY _____ LATEX ALLERGY _____ CANNOT SWALLOW PILLS

PLEASE CHECK which of the following medications you WILL ALLOW your child to be given by nurse. Doses will be given according to the child's age and weight according to medical director's order. Medications are not dye-free and those with an * contain red dye and will not be administered to anyone stating they have a red dye allergy.**

_____ Acetaminophen (Tylenol)*** _____ Ibuprofen (Advil/Motrin) _____ Orajel*** _____ Hydrocortisone Cream _____ Calamine Lotion

_____ Antacid*** _____Anti-Nausea Medicine *** _____ Antihistamine for allergy symptoms _____ Bacitracin Ointment

_____ Sun Screen _____Aloe Vera (for burns) _____ Sore Throat Lozenge/ Cough Drop*** _____ Cough Syrup ***

Any medications checked will be administered, as per your consent, without contact from the school nurse. A copy of the nurse's notes will be sent home to the parent/guardian stating what medications were given, dosage, and time. It is the child's responsibility to get this copy to the parent/guardian. The school nurses cannot take consent to give medications over the phone.

IF THIS INFORMATION SHOULD CHANGE, PLEASE NOTIFY THE SCHOOL NURSE IMMEDIATELY.

CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS (Valid for school year listed above)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include screenings such as vision, hearing, and dental screenings, physical exams, treatment, first aid, over the counter medication as indicated above, and any other health service given to my child by Med Center Health. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I like-wise release the staff from any liability related to the administering of the above medications to my child as long as the responsibility is discharged according to the above instructions. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a health care worker is exposed to his/her blood. body fluids, or tissue. I authorize the school health clinic to release and receive medical information about my child, as permitted by the Health Insurance Portability Act of 1996 (HIPPA), to his/her primary care provider and to share pertinent medical information (history of allergies or significant medical history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I also give permission for school health clinic staff to view my child's Individual Education Plan (IEP). Further, I understand that information obtained during school physicals and immunization information will be released to my child's school. I authorize Med Center Health to release medical information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of Med Center Health's Privacy Notice.

I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_________________________________ _________________________________ ____________________

(Signature of Custodial Parent/Guardian) (Printed Name of Custodial Parent/Guardian) (Date Signed)