SCHOOL BASED HEALTH CLINIC

Marion School District has partnered with East Arkansas Family Health Center in opening a school health clinic on the campus of Marion High School.

If you would like for your child to utilize the clinic in the future,you will find an attached parental consent form. Please read over the consent form and fully answer all of the questions about your student. Notice that there are three places for parents to choose “yes” or “no”, followed by a required signature by the parent at the bottom of the last page.

Please return the signed consent to your child’s homeroom teacher, front office, or school nurse.

Thank you and we look forward to assisting your child with his/her medical needs this year!

*******Parent/Guardian will always be notified before any child is transported or seen in the health clinic.

Updated/Reviewed: 2/2020

Health History Form and Consent to Treat

A. Student Information

Name **Gender** **Date of Birth** **Age** **Social Security #**

Mailing Address **City** **Zip** **Telephone#**

Name of Insurance Co. **Group #** **Claim #**

Name of Guarantor **Guarantor Date of Birth** **Relationship**

Emergency Contact **Relationship** **Telephone #**

Secondary Emergency Contact **Relationship** **Telephone #**

Race/Ethnicity: __White/Caucasian __African American/Black __ Hispanic/White __Asian __Native Hawaiian
__ American Indian __ Other Pacific Islander __Refuse to Report

Name of Primary Care Provider/Physician **Address** **Telephone #**

Name of Pharmacy **Address** **Telephone #**

In order to determine eligibility for patient assistance programs and for federal reporting necessary to continue funding for this facility, please complete:

Number of Household Dependents: _____ **Gross Household Income: $_____**
Does the student receive free/reduced lunch? **YES** **NO**

Please circle any options that apply to the patient: **Veteran** **Homeless** **Live in Public Housing** **Migrant** **None**

B. Personal and Family History: Please check all that apply regarding present and past health history:

	Student	Mother	Father	Grandparents	Sister/Brother
Asthma					
Anemia					
Allergies					
Birth Defects					
Behavioral Concerns					
Cancer/Tumor					
Chickenpox					
Diabetes					
Depression					
High Blood Pressure					
Heart Attack/Disease					
Kidney Disease					
Sickle Cell					
Seizures					
Stroke					
Whooping Cough					
Liver Disease					
Skin Conditions					
Stomach Problems					
Mental Illness					
Other:					

Allergies (including food, pollens, odors, medicines, pets, etc) ___ YES ___ NO
If yes, please list: _____

Current Medications (including vitamins/OTC/Supplements)	**Dose:**	**Times/Day:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations: ___ YES ___NO
Past Surgery: ___ YES ___ NO
If yes, please list specific information below:

Reason	**Location**	**Month/Year**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other medical problems that your child has that we need to know about:
_____
_____
_____
_____
_____

***Please note that a School Care Plan/Physician's written diagnosis is required for all special medical needs concerning your child, such as a special diet, allergies, asthma, seizures, etc.**

C. Primary Care Provider Referral Agreement
In order for East Arkansas Family Health Center, Inc. to receive reimbursement from Medicaid or commercial insurance, a referral from the current PCP may be required. However, if a referral cannot be received from the PCP, East Arkansas Family Health Center, Inc. asks the parent to change the student's PCP to East Arkansas Family Health Center, Inc. in order to receive reimbursement for services. All patients may apply for Sliding Fee discounts.

D. Financial Assistance
In an effort to ensure that payment of fees is not a barrier to care, East Arkansas Family Health Center, Inc. offers those who need it a waiver of fees. All waivers will be specific to location and services approved.
___ YES, I request a waiver of fees.

___ NO, I do not request a waiver of fees. I understand all services will be billed directly to me including co-pays and deductibles for services rendered.

E. Transportation Consent

It may be necessary for the student to be transported to the Health Center. If so, I give consent for my child to be transported to the Health Center by a school employee.

___YES, I consent to my child being transported.

___NO, I do not consent to my child being transported.

F. Consent to Treat- School Based Health Center
I understand that the School Based Health Center can provide health services to my child. One consent form per child must be signed and on file in order for the student to receive services.

By signing below, I hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the provider. I further understand that any services provided but processed by a third party contractor

(AEL Corp) such as routine laboratory work (including but not limited to blood, urine, and/or swabs) may be billed to me directly. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, including nurses, as is necessary per provider judgment.

Regarding release of information: (a) I authorize the clinic to release medical information to the third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care. (b) I further authorize the release of medical information about treatment here to my (his/her) doctor or any designated by me for continuity of care. (c) I further authorize the ability to view prescriptive history from external sources. (d) I further authorize the release of medical information to federal and state governing entities for the purposes of required reporting.

I understand that the Arkansas State Medical Board, Arkansas State Board of Nursing, and other federal and state agencies license and regulate all medical providers, including East Arkansas Family Health Clinic, Inc. (EAFHC) and its health care providers and staff. Marion School District (MSD) provides space and access to this clinic for its staff and students but does not provide oversight for the provision of medical services through this School Based Health Center. I and my child/ward agree to hold harmless MSD, its employees and agents for any and all claims that may arise through the provision of medical services given, authorized, or directed by EAFHC, its employees, independent contractors, and agents. Further, I and my child/ward agree to hold harmless MSD, its employees and agents for any and all claims that may arise during the transportation of my child/ward to and from the EAFHC clinic whether the transportation is in a privately owned vehicle or in a vehicle owned by MSD.

I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the School Based Health Center and that no person is turned away due to the inability to pay. I understand that the Notice of Privacy Practices document has been provided to me.

_____YES! I consent for my child to receive <u>MEDICAL</u> care through the School Based Health Center (examples: physical exams, well child visits, lab, evaluation of injuries, vaccinations, and chronic disease management).

_____	_____	_____
Signature of Parent/Guardian	**Relationship**	**Date**

G. Denial of Consent to Treat- School Based Health Center.

_____ No, I do not wish for my child to receive medical care through the School Based Health Center.

_____	_____	_____
Signature of Parent/Guardian	**Relationship**	**Date**

MARION SCHOOL DISTRICT MEDICAL FORM

Student's First Name_____ Middle Name_____ Last Name_____

Student's Grade_____ Age_____ Gender:_____Male _____Female Date of Birth:_____

Parent/Guardian Name_____ Phone_____

GENERAL MEDICAL INFORMATION

Allergies: (Circle type of reaction) *life threatening implies respiratory distress or need of emergency care

- ❑ Foods/Nuts _____ Life Threatening* Severe Mild
- ❑ Insects _____ Life Threatening* Severe Mild
- ❑ Medications _____ Life Threatening* Severe Mild
- ❑ Other _____ Life Threatening* Severe Mild
- ❑ My child has an epinephrine pen for the above allergy

** Physician order required yearly for cafeteria substitutions due to food allergies.

Eyes: Wears Glasses: Y or N Wears Contacts: Y or N If yes, date of last eye doctor appointment?_____

Ears: History of ear infections: Y or N Had Tubes: Y or No Age:____ Has Tubes now: Y or N

Does your child have now or ever had any of the following?	Currently has	Has had in the past	Taking medication for condition? If yes, list medication
Asthma			
Seizures			
Diabetes			
High Blood Pressure			
Migraines			
ADD/ADHD			
Heart Problems (specify): _____			
Psychiatric Problems (specify): _____			
Other (specify): _____			

Does your child have one or more of the following disabilities?	YES	NO
Autism		
Down Syndrome		
Intellectually Disabled		
Crutches/Braces		
Wheelchair		
Deaf/Hearing Impaired		
Blind/Visually Impaired		
Implant-head		
Implant- spine		
Impaired swallowing		
Bowel/Bladder disorder		
Other (specify): _____		

Will your child need medication at school?_____ If yes, list medication(s)_____

NOTE: If your child will take medicine at school, you must complete a medication administration release form from the nurse. All medication must be administered through the nurse and/or front office. Medication must be brought to the nurse by a parent/guardian.

Authorization for Medical Treatment: If parent, guardian, or person designated cannot be reached, Marion School District has authority to give consent for emergency medical treatment. The school district is in no way financially responsible for medical treatment. Permission is also given for my child to take acetaminophen (Tylenol) in event of fever of 103 degrees or above when a parent cannot be reached. Permission is given for my child to receive over the counter topical ointment treatments for minor first aid such as:neosporin, hydrocortisone, antifungal cream, blistex, burn cream, and insect sting relief.

Parent/Guardian Signature_____ **Date**_____

Revised 2/13/2020

Protected Health Information

The Marion School District School Health Program is under the direction of the Health Service Team. The team acts as a liaison between the home, school, and the community. The team consists of the Director of Nursing, a nurse from each school building, and a physician.

Health history and medical information obtained concerning students or staff will be kept in confidence. For the sake of ensuring an optimal learning and safe environment, some information relating to the health and safety of a student may be shared with other faculty members and emergency personnel on a need-to-know basis as deemed necessary by the Health Services Team and administration.

Health Service Team Members: Dr. Aaron Mitchell, Cassie King, RN, Harriet Morrow, RN, Carmen Davis, LPN, Director of Nursing- Kelly Fogleman RN, Denise Letner, LPN, Shawanna Stokes, RN, and Brenda Alexander, RN.

As a parent or guardian of the above student, I have read the above guidelines of the Protected Health Information. I recognize that health records once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. If there is any objection with health information being shared, such objection must be put in writing and given to your child's school.
Be sure to keep your child's emergency contact information up-to-date in the school office. The school must be able to contact you in case of an emergency.

Parent or Guardian's Signature _____

Date_____

Student Signature _____

Date _____

Revised 2020-2021

Marion School District

Re: Vision & Hearing Services

Dear Parent/Guardian:

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of Vision & Hearing services that the school district provides for students. In order to seek the federal Medicaid funds for reimbursement, the school must disclose information from your child's records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to Medicaid agencies. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

If your child has Medicaid or ArKids 1st, please fill out, sign, and return this form to their school.
In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g;34
CFR Part 99)

I,_____
(Parent/Guardian Name)

Give permission for my child_____
(Child's first and last name)

personally identifiable information/student education records to be disclosed to Marion School District for the purpose of billing Medicaid.

Child's Date of Birth: _____

Child's Medicaid or ArKids 1st Number _____

_____
(Printed name of Parent/Guardian)

_____ _____
Parent/Guardian Signature Date

PLEASE SIGN AND RETURN TO SCHOOL