Heritage Health
Healthcare from the Heart

Primary Care | Family Dental | Psychiatric | Counseling | Pediatrics | Post-Acute Care | Substance Use Treatment

HERITAGE HEALTH SCHOOL BASED HEALTH CENTER | CONSENT FOR SERVICES

ACADEMIC YEAR 2017-18

Heritage Health School-Based Health Center (SBHC) must have a signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access such treatment without parent/guardian consent.

If the student is enrolled in school but is not enrolled in a School-Based Health Center (SBHC), he/she can continue to receive School Nurse services.

I hereby request and authorize that the student named below receive health/mental health care services
____ Only with a parent/guardian present
____ Independently (parent/guardian will be notified prior to evaluation and management of student) available from and deemed necessary by the staff of the SBHC. These services may include, but are not limited to: routine medical exams, sports physicals, well-child care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, x-rays, dental and fluoride treatment services, mental health counseling.

Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the SBHC staff.
This authorization does not allow services to be rendered without the student's consent, unless she/he is unable to consent.

Heritage Health collaborates with other providers in the community that may also be seeing patients we serve to ensure care is coordinated. I authorize my child's primary care provider to share clinical information, as appropriate, with the SBHC staff to support treatment of my child, and I give permission to the SBHC staff to share information with the primary care provider as appropriate.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist, for example:

- Permission is given by the patient to parent/guardian through a signed release of information.
- The patient indicates risk of imminent harm to self or others.
- The patient has a life-threatening health problem and is under 18 years old.
- There is reason to suspect abuse or neglect.
- Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care providers at the SBHC, including exchange of information between the mental health therapist, nurse practitioner or physician's assistant and the School Nurse, for the purpose of providing the best care for the above named student.

To facilitate coordination of care, the student's School-Based Health Center medical record will be accessible to Heritage Health staff at the SBHC. Consent is granted for the School Nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the medical provider of the SBHC. Students may also receive services independently at Heritage Health's other clinics. Consent is authorized for services provided by Heritage Health during the length of time the student is enrolled in a school with a Heritage Health SBHC or for the length of time services are provided at another Heritage Health clinic. Withdrawal of this consent can be done at any time by writing to the SBHC.

Student Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____

Name of Legally Responsible Guardian (Print):_____

Relationship: _____

P.O. Box 3648,
Coeur d'Alene, ID. 83816

myheritagehealth.org
208.620.5250

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- PATIENT INFORMATION -

PLEASE PRINT

Name: _____

Sex: Male ☐ Female ☐ DOB: ____/____/____ SS#____-____-____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: *(Home)*(____)_____ *(Cell)*(____)_____ *(Work)*(____)_____

Email: _____ **I authorize Heritage Health to contact me at the above email address regarding my protected health information and care: Yes ___ No ___ Initial _____**

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone:(____)_____

Pharmacy/Name/Location: _____

Responsible Party

Name: _____ Relationship: _____

DOB: ____/____/____

SS#____-____-____ Address: _____

Phone:(____)_____

INSURANCE INFORMATION - Includes MEDICAID/MEDICARE Information

Insurance Company: _____ Policy #_____ Group #_____

Insured: _____ DOB: ____/____/____ SS #____-____-____

Secondary Insurance: _____ Policy # _____ Group #_____

Insured: _____ DOB: ____/____/____ SS# ____-____-____

_____ ____/____/____

Signature of patient/responsible party **Date**