# Walk-in Care FOR SCHOOLS

## CONSENT FOR SERVICES 2020-2021 SCHOOL YEAR

KING'S DAUGHTERS

## INITIAL OFFERING OF SERVICES

❑ Yes. I would like my child to access these services. I have completed all the information.

❑ No, I do not want my child to access these services. If so, please check this box, **include the date and student's name below,** and return the form.

Please read carefully: In order for King's Daughters ("KDMC", "we" or "us") to see a student at the school listed below, all pages of this form must be completed by the student's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their homeroom teacher or other appropriate school representative. Consent is for the 2020-2021 school year and may be withdrawn at any time in writing by the signatory below.

## 1. STUDENT INFORMATION

Today's date: / /

School district: School name:

Student name: Gender: ❑ Male ❑ Female

Date of birth: / / Social Security No.: - -

Address:

City: State: Zip code:

Home telephone: Mobile telephone:

## 2. EMERGENCY CONTACT INFORMATION

**Mother** or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

**Father** or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

**If parents or legal guardians are not available, please contact:**

Name and relationship to student:

Home telephone: Mobile telephone:

Work telephone: Email address:

## 3. STUDENT'S MEDICAL HISTORY

This information will aid in making an accurate assessment in case of illness or emergency. Please check if the student has ever had the following:

❑ Anaphylatic episodes
❑ Anemia
❑ Asthma
❑ Birth defects
❑ Blood transfusions
❑ Chest pain
❑ Chicken pox
❑ Cough-persistent
❑ Diabetes
❑ Fatigue-unexplained
❑ Head/eyes/ears/throat problems
❑ Joint/muscle pain/ stiffness
❑ Leukemia
❑ Measles
❑ Mumps
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Shortness of breath
❑ Sleep problems
❑ Stomach/bowel problems
❑ Tuberculosis exposure
❑ Weight gain-unexplained
❑ Weight loss-unexplained

Please explain any checked items:

Medications take by the student on a regular basis:

Does the student have allergies to food, medications or environmental pollens?....❑ Yes ❑ No

If yes, please list: _____

You will be asked to complete a separate medication consent form if you want King's Daughters to administer this medication at school.

Last time student was seen by a medical provider (please provide reason, date and provider's name): _____

_____

Student's medical provider: _____ Telephone: _____

Student's dentist: _____ Telephone: _____

Student's pharmacy: _____ Telephone: _____

❑ Operations (reason/date): _____

❑ Hospitalizations (reason/date): _____

❑ Serious injuries or illnesses (describe): _____

Have there been any recent incidents in the family that might have affected student? .....❑ Yes ❑ No

If yes, please explain: _____

_____

_____

## 4. STUDENT'S FAMILY MEDICAL HISTORY

Please check the appropriate space if any of student's close blood relatives (e.g., mother, father, brother, sister) have any of the following conditions:

❑ Alzheimer's
❑ Arthritis
❑ Asthma
❑ Birth defects
❑ Bleeding disorders
❑ Cancer
❑ Cholesterol-high
❑ COPD/emphysema/ bronchitis
❑ Diabetes
❑ Epilepsy/seizures
❑ HIV/AIDS
❑ Heart attack/stroke
❑ High blood pressure
❑ Kidney disease
❑ Liver disease/hepatitis
❑ Mental illness
❑ Osteoporosis
❑ Sickle cell
❑ Substance abuse disorder
❑ Thyroid disorder
❑ Tuberculosis/TB
❑ Other: _____

## 5. STUDENT'S IMMUNIZATION STATUS

Is student up to date on immunizations?.....❑ Yes ❑ No Where is student's immunization record on file? _____

❑ Yes, I give permission for King's Daughters or the school to request a copy of student's immunization record.

## 6. OTHER INFORMATION ABOUT STUDENT

Do you have concerns about student's health?.....❑ Yes ❑ No Is student exposed to secondhand smoke?.....❑ Yes ❑ No

Does student smoke or use tobacco products? .....❑ Yes ❑ No Does student drink alcohol?.....❑ Yes ❑ No

If you answered "Yes" to any of the questions above, please explain: _____

Please check any over-the-counter medications below you **do not** want student to receive:

❑ Acetaminophen (generic name for Tylenol)
❑ Claritin for allergies
❑ Cough drops
❑ Diphenhydramine (generic for Benadryl)
❑ Eye wash, irrigating solution
❑ Hydrocortisone 1% cream
❑ Hydrogen peroxide (for wound cleansing)
❑ Ibuprofen (generic name for Advil)
❑ Imodium for diarrhea
❑ Lip ointment (Blistex, Chap stick, etc.)
❑ Lotion
❑ Refresh Plus eye drops/Refresh
❑ Solarcaine spray for burns and scrapes
❑ Sore throat spray
❑ Sting relief swabs
❑ Topical antiseptic (benzalkonium chloride)
❑ Topical mouth/tool pain reliever (Orajel, Orasol, etc.)
❑ Tums
❑ Triple antibiotic ointment (Neosporin, Bacitracin, etc.)
❑ Tussin DM

## 7. INSURANCE INFORMATION

Please complete the following insurance information for student. This information is required for student's health record to be complete but will only be billed if services are provided by King's Daughters. School nurse visits are not billed to insurance. **Please fully complete and attach copy of insurance card.**

**PRIMARY POLICY**

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of primary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of primary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

**SECONDARY POLICY**

Do you have another health insurance policy that may provide additional coverage?..... ❑ Yes ❑ No If yes, please provide information below.

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of secondary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of secondary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

## 8. CONSENT AND PERMISSION

By my signature below, I hereby give consent for student to receive the following services from King's Daughters at:

School district: School name:

1. Annual well visits (please provide the date of student's last annual well visit): _____
2. Physical/wellness exam
3. Sports physical exam
4. Acute visits
5. Lab draws
6. Point of care testing
7. Flu immunizations (the flu immunization and all other immunizations will require a separate consent)
8. Tb skin testing
9. Medication administration (including over-the-counter items not prohibited in Section 6 above)
10. Drug dispensing
11. Education
12. Telemedicine (which are services provided remotely by King's Daughters to student at school and for which a separate consent is required)
13. Other: _____

Would you like your child to have their yearly physical (wellness visit) with our provider while at school?..... ❑ Yes ❑ No

If you object to King's Daughters providing student with any of the services listed above, please explain: