Walk-in Care FOR SCHOOLS

CONSENT FOR SERVICES 2017-2018 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 Consent is for the 2017-2018 school year and may be withdrawn at any time in writing by the signatory below.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 ❑ Leukemia ❑ Scarlet fever ❑ Stomach/bowel problems ❑ Weight loss-unexplained
❑ Joint/muscle pain/ stiffness ❑ Measles ❑ Seizures ❑ Tuberculosis exposure
❑ Mumps ❑ Shortness of breath ❑ Weight gain-unexplained
❑ Rheumatic fever ❑ Sleep problems

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:

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

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

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: _____

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

Prior to providing any of the services above, King's Daughters or school will make a courtesy call to you and will accommodate, within reason, your request to be present when services are rendered. However, if we are unable to reach you, we will still provide services to student pursuant to this consent.

In addition, by my signature below, I hereby give permission as follows:

1. To King's Daughters to review student's school record, including attendance and other information, if applicable, that will assist in treating student;
2. On behalf of student to participate in ongoing evaluations administered by King's Daughters, including questionnaires and surveys;
3. To King's Daughters to disclose to appropriate school staff the medical information of student, as King's Daughters deems necessary;
4. To the following hospitals to release to King's Daughters student's emergency room reports: _____
5. To King's Daughters to disclose to any appropriate agencies or medical practitioner any medical and billing information that may result from student's contact with (include clinic name): _____
6. To King's Daughters to obtain any records or information from any agency or private professional regarding student's care.

At the end of this form, please provide an email address for an account that you regularly check. This will enable you to register for MyChart, an online service that will provide you with easy, confidential access to student's medical records.

By my signature below, I agree to provide King's Daughters with updated or additional information applicable to Sections 3 through 6 of this form, as necessary. This includes information related to the medications taken by student and the over-the-counter medications you wish student not to receive.

9. RELEASE OF INFORMATION FOR BILLING PURPOSES

By my signature below, I hereby authorize the release of student's medical information to applicable third-party payors, governmental agencies, and other organizations, as necessary for billing purposes only. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV-related diagnosis information, if any, as may be contained in student's records. I understand that I have the authority to release the above referenced medical records on behalf of student. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third-party payors pursuant to KRS 214.420.

10. PRIVACY AND ASSIGNMENT OF BENEFITS

This form has been fully explained to me. I have been given an opportunity to ask questions and am satisfied that I understand its content and significance. By my signature below, I agree that the information I've provided in this form is true and accurate to the best of my knowledge. I understand that King's Daughters shall provide a copy of their Notice of Privacy Practices upon my request, and that said Notice is also available at kingsdaughtershealth.com. I also request payment of authorized medical insurance benefits be made to King's Daughters on student's behalf for services he/she receives. I realize I am responsible to pay for any non-covered services student receives and/or services requiring insurance authorization.

Date: _____

Signature of the parent/legal guardian: _____

Telephone: _____

Email: _____