# Primary Health Care, Inc. School Based Health Center Consent to Treat Form

Name of Student _____ Date of Birth _____ Grade _____

I understand that the School Based Health Center (SBHC) can provide health service for students enrolled in the Des Moines Public Schools. One consent form per student must be signed and on file at the health center for the student to receive these services. By marking yes I consent to the following services:

☐ **Yes.** I consent to having my child receive **medical care** through the SBHC. I acknowledge that such medical care may include, without limitation: physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, and referrals as well as other services as described below. **Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian.**

☐**Yes.** I consent to my child being transported to appointment by Des Moines Public Schools Transportation to the SBHC.

I understand that this Consent Form may be revoked in writing at any time and that the revocation will take effect on the day it is received by Primary Health Care, Inc. at the School Based Health Center.

**Parent/Guardian Information**

Mother/Guardian _____ DOB _____ Primary Phone _____ Other Phone _____

Father/Guardian _____ DOB _____ Primary Phone _____ Other Phone _____

Parent/Guardian Address _____

Parent/Guardian email: _____

**Health Insurance (Please circle and complete, if applicable):**

**Medical & Dental Insurance:** Uninsured Medicaid/Hawk-I ID#_____ Private Insurance ID/Group#_____ SSN#_____

Policy Holder's name & DOB _____ Employer _____

Policy Holder's Address _____

****NOTE: Primary Health Care, Inc. will treat patients regardless of their ability to pay.**

## School Based Health Centers

The SBHC will be available at your child's school or nearby school. The SBHC will be staffed and operated by Primary Health Care, Inc (PHC). PHC will be able to test for, diagnose and treat many common conditions such as sore throats, headaches, ear infections, as well as other infectious disease such as hepatitis, tuberculosis and sexually transmitted infections. [NOTE: Iowa state law (Iowa Code § 139A.35) allows students to choose whether or not a parent will be notified of a student's care related to sexually transmitted infections]. PHC will provide care for minor injuries but will not provide emergency services. PHC will also provide services such as immunizations, contraceptive services and make appropriate referrals to other providers as needed. PHC will attempt to coordinate care with your child's primary care provider as long as PHC has been provided information on such primary care provider. If you have private health insurance or Medicaid/Hawk-I, PHC will provide services and submit the bill to your insurance carrier. If you do not have such coverage, PHC staff will work with your family to help enroll your child(ren) in Medicaid/Hawk-I, if eligible.

## Primary Health Care, Inc. - Consent to Treatment & Release of Information

To enroll your child at the SBHC, and in order for the Des Moines Public School (DMPS) District to give PHC staff confidential information to help with diagnosis and treatment, this signed and completed Consent form must be on file at DMPS and PHC. PHC staff will typically attempt to contact you to inform you of the reason for your child's visits and the services provided. By signing this enrollment and consent form, you consent to the following:

- I authorize the sharing of information regarding my child between the Primary Health Care, Inc., Dental Connections, and Des Moines Public Schools.
- I authorize PHC to examine and treat my child at the SBHC, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- I authorize DMPS and any of its certificated staff, including the school nurse at my child's school, to communicate and share information to assist PHC to treat my child, including my child's family and emergency contact information, attendance records and disciplinary information, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and any health conditions such as seizures or asthma.
- I authorize PHC staff members to release any medical records required by the insurer or other payer to obtain payment. Following applicable legal requirements, PHC staff members may use and share my child's medical information for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. A Notice of Privacy Practices document is available to me at the location my child receives his/her health care services and on the PHC website.
- **Unless otherwise revoked, this Authorization expires 12 months after the date of my signing this form.**

**By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent.**

Parent/Guardian signature_____ Relationship to Child_____

Date _____

## About Our Notice of Privacy Practices

We are committed to protecting your child's personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your child's personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

**I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.**

_____

**Patient's Signature**

_____

**Date**

_____

**Signature of Parent or Patient's Representative (if applicable)**

_____

**Date**

_____

**Description of Legal Authority to Act on Behalf of Patient**

Date of Revision: 2/2017

## Medicine, Allergies, & Health History

**(Please mark all that apply with an [X])**

**Is your child allergic to any of the following?**

[ ]Anesthetics [ ]Sulfa [ ]Latex [ ]Aspirin [ ]Codeine

[ ]Penicillin/Amoxicillin [ ]Other Medicines:_____

_____

[ ]Foods:_____

[ ]Environmental:_____

[ ]Other:_____

## General Provider and Pharmacy Information

Who is your child's Primary Care Provider (PCP)?

When was your child's last visit with his/her PCP?
Date (or approximate date):

Who is your child's Dental Provider?

When was your child's last dental visit?
Date (or approximate date):

Please list any other Providers your child regularly sees?
(i.e. ENT, Psychiatrist, Cardiologist, etc.):

What Pharmacy do you use? What is the address (or cross-streets)?

Please circle **YES** or **NO** to the following questions

**Is your child taking medicine? NO / YES-please list:**

Have you taken your child to the hospital recently?
**NO / YES-Where and Date:**

Has your child been to any clinics or urgent care centers for any health problems recently? **NO / YES-Where and Date:**

Any issues with the pregnancy or birth of your child?
**NO / YES-please explain:**

## Medical and Mental Health Conditions:

**(Please mark all that apply with an [X])**

| | |
|---|---|
| [ ] ADHD | [ ] High Blood Pressure |
| [ ] Allergies | [ ] HIV/AIDS |
| [ ] Anemia | [ ] Hearing Impairment |
| [ ] Anxiety | [ ] Heart Condition |
| [ ] Arthritis | [ ] Hepatitis |
| [ ] Asthma | [ ] Liver Condition |
| [ ] Autism | [ ] Kidney Condition |
| [ ] Behavioral Concerns | [ ] Muscular Dystrophy |
| [ ] Bladder Problem | [ ] Orthopedic Condition |
| [ ] Bowel Problem | [ ] Seizure |
| [ ] Celiac Disease | [ ] Sickle Cell Anemia |
| [ ] Cerebral Palsy | [ ] Skin Condition |
| [ ] Cystic Fibrosis | [ ] Spina Bifida |
| [ ] Depression | [ ] Thyroid Condition |
| [ ] Diabetes | [ ] Tuberculosis |
| [ ] Dizziness/Fainting | [ ] Vision Impairment |
| [ ] Downs Syndrome | [ ] Wears glasses/contacts |
| [ ] Epilepsy | [ ] Other: |

Any past Serious Injuries or Accidents? **NO / YES-Please list:**

Has your child ever been in the hospital? **NO / YES-When and Why:**

Has your child ever had surgery? **NO / YES-When and Why:**

## General Health

| | |
|---|---|
| Do you consider your child to be in good health? | **NO / YES** |
| Has your child ever had a head or mouth injury? | **NO / YES** |
| Do you think your child has any cavities or toothaches? | **NO / YES** |

Does your child need medicine before dental treatment because of heart or other medical conditions? **NO / YES-Why:**

Is your child pregnant? **NO / YES / MAYBE**

Are there any concerns with your child's physical, mental, and or emotional development? **NO / YES-please explain:**

Any concerns regarding your child's school performance?
**NO / YES-please explain:**

## Family History

Does your child's biological **mother** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Does your child's biological **father** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Does your child's biological **siblings** have any medical problems?
(example: asthma, diabetes, heart disease, etc.) **NO / YES-please explain:**

Which do you consider your child?

[ ] White [ ] Hispanic-Latino [ ] African-American

[ ] Asian [ ] American-Indian [ ] Other

Does your child qualify for free/reduced lunch at school? **NO / YES**

## Who Lives at Home?

| | | |
|---|---|---|
| Mother | **NO / YES** | Name: |
| Father | **NO / YES** | Name: |
| Sister(s) | **NO / YES** | How many? |
| Brother(s) | **NO / YES** | How many? |
| Other People | **NO / YES** | How many? |

## Home Environment

| | |
|---|---|
| Do you have enough food at home? | **NO / YES** |
| Does someone else care for your child? (daycare, after school care, family member, etc.) | **NO / YES** |
| Does anyone smoke inside the home? | **NO / YES** |
| Do you live in your own home/apartment? | **NO / YES** |
| Or do you stay at someone else's place? | **NO / YES** |
| Do you feel safe in your home? | **NO / YES** |

Is there any other information about your home environment that would be helpful for us to know when caring for your child?
**NO / YES-please explain:**

Is there any other information you would like to share with your provider?

Dental connections
*Building a community of smiles.*

Primary HealthCare