OMAHA PUBLIC SCHOOLS
School Based Health Centers Enrollment and Consent Form
Enrollment is OPTIONAL

2017-18

Student Information

Revised 07/01/2016

Student Last Name (legal): Student Number:
First Name (legal): Student Middle Name (full):
Home Address: City: Zip:
Gender: M / F Birth Date (month/day/year): / /
Grade: Name of School Attending:

Parent/Guardian Information

Parent Last Name (legal): Parent First Name (legal):
Parent Middle Name (full): Parent Birthdate (mm/dd/yy):
Parent/Legal Guardian: Yes / No Relationship to Student:
Home Phone: Work Phone: Cell Phone:
Email: May we text your cell phone number? ❑ Yes ❑ No

Parent/Guardian Information

Parent Last Name (legal): Parent First Name (legal):
Parent Middle Name (full): Parent Birthdate (mm/dd/yy):
Parent/Legal Guardian: Yes / No Relationship to Student:
Home Phone: Work Phone: Cell Phone:
Email: May we text your cell phone number? ❑ Yes ❑ No

Medical Emergency Contact Information (Other than Parents/Guardian)

Last Name: First Name:
Relationship to Student:
Home Phone: Work Phone: Cell Phone:
Does your child have a regular Physician/Doctor? ❑ Yes ❑ No ❑ Unknown/Unsure
Physician Name: Physician Phone:
Insurance: ❑ Medicaid/Kids Connection ❑ Commercial: _____ ❑ No Health Insurance
Policy #/Enrollment ID: _____ Phone: _____
Dental Insurance: ❑ Commercial: _____ ❑ No Dental Insurance Policy #: _____

School Based Health Services

School-based health services will be available at your child's school or a nearby school during the school year. These services will be provided by OneWorld Community Health Centers, Charles Drew Health Center, UNMC or Creighton University. The school nurse will coordinate care with the school-based health service providers once your child is enrolled. The services include:

- **School Based Health Centers (SBHC)**: ability to screen health status, test for, diagnose and treat many common conditions such as sore throats, minor injuries headaches, immunizations, ear infections, and other infectious diseases such as hepatitis, tuberculosis and sexually transmitted diseases. Nebraska state law allows students to choose whether a parent will be notified of a student's care related to sexually transmitted infections. The SBHC will not provide emergency services. The SBHC may also provide behavioral and/or psychiatric services for children and adolescents. Services may also include the use of telehealth technology.
- **Dental Services**: services may include oral health education, screenings, fluoride varnish application, preventative care and cleaning, restorative/corrective care, and use of telehealth technology.

School-based health service providers will attempt to coordinate care with your child's primary care provider, dentist and/or behavioral health provider. If you have private health insurance or Medicaid, the school-based health service providers will submit the bill to your insurance carrier after services are provided. If you currently do not have health insurance, the school-based health service provider will work with families to help enroll your child(ren) in Medicaid, if eligible.

Sharing Student Information

OPS maintains student information in its own files and databases and in the Omaha Data Collaborative database operated by United Way of the Midlands. OPS permits school-based health service providers to access student information from all of these sources in order to deliver services and to help evaluate the school-based health services program and its impact on student success. OPS ordinarily requires parental consent for release of non-directory information unless a student visits a center with a health need and the parent has not yet enrolled the student, but in such cases the parent will be promptly contacted.

Consent to Treatment and Release of Information

To enroll your child in school based health services, and in order for OPS to give provider staff confidential information to help with diagnosis and treatment, a signed enrollment and consent form must be on file with OPS and SBHC provider. The SBHS staff will typically attempt to contact you to inform you of the reason for your child's visit and the services provided. By signing this enrollment and consent form, you consent to the following:

- I authorize OneWorld Community Health Center, Charles Drew Health Center, UNMC, and/or Creighton to examine and treat my child with school-based health services, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- In the event that trained school personnel such as school nurses or health aids are not available to give prescribed medications routinely taken at school, I authorize SBHC staff to administer such medications to my child.
- I authorize OPS and its certificated staff, including the school nurse at my child's school, and United Way of the Midlands on behalf of OPS, to release the following student information to the school-based health services providers identified above so that they can provide services and conduct program evaluation: child's family and emergency contact information, state student number, attendance and disciplinary records, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and information regarding any health condition, such as seizures or asthma.
- Students leaving the elementary or middle school level will need to re-enroll at the next level.
- This authorization expires when my child leaves elementary, middle or high school, leaves the school district, or graduates.

You may revoke this authorization at any time by submitting a letter to the Omaha Public Schools, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024.

Parent/Guardian Signature:	Relationship to child:	Date:

Office Use Only: ☐ Verified ☐ Programs ☐ Sections Initials

ESCUELAS PÚBLICAS DE OMAHA

Formulario de Inscripción y Consentimiento del Centro de Salud Basado en la Escuela

2017-18

Inscripción es OPCIONAL

Información del Estudiante

Apellido del Estudiante (legal): Número de Estudiante:

Primer Nombre del Estudiante (legal): Segundo Nombre del Estudiante (completo):

Dirección: Ciudad: Código Postal:

Sexo: M / F Fecha de Nacimiento (mes/día/año): / /

Grado: Escuela Actual:

Información de los Padres/Tutores

Apellido del Padre/Madre/Tutor (legal): Primer Nombre (legal):

Segundo Nombre (completo): Fecha de Nacimiento (mes/día/año):

Padre/Madre/Tutor Legal: Sí / No Relación con el Estudiante:

Teléfono de la Casa: Teléfono del Trabajo: Celular:

Correo Electrónico: ¿Podemos mandarle un mensaje de texto a su teléfono celular ? ❑ Sí ❑ No

Información de los Padres/Tutores

Apellido del Padre/Madre/Tutor (legal): Primer Nombre (legal):

Segundo Nombre (completo): Fecha de Nacimiento (mes/día/año):

Padre/Madre/Tutor Legal: Sí / No Relación con el Estudiante:

Teléfono de la Casa: Teléfono del Trabajo: Celular:

Correo Electrónico: ¿Podemos mandarle un mensaje de texto a su teléfono celular ? ❑ Sí ❑ No

Información de Contacto en caso de Emergencia Médica (Aparte de los Padres/Tutores)

Apellido: Primer Nombre:

Relación con el Estudiante:

Teléfono de la Casa: Teléfono del Trabajo: Celular:

¿Tiene su hijo un Médico/Doctor regular? ❑ Sí ❑ No ❑ Desconocido/inseguro

Nombre del Médico: Teléfono del Médico:

Seguro Médico: ❑ Medicaid/Kids Connection ❑ Comercial: _____ ❑ No Seguro Médico

Número de Póliza/ID de Inscripción: Teléfono:

Seguro Dental: ❑ Comercial: _____ ❑ No Seguro Dental # de Póliza: _____

Servicios de Salud basados en la Escuela

Servicios de Salud basado en la Escuela estará disponible en la escuela de su hijo o en una escuela cerca durante el año escolar. Estos servicios serán provistos por los Centros de Salud de "OneWorld" o "Charles Drew ", UNMC o la Universidad de Creighton. La enfermera de la escuela coordinará el cuidado con el centro de salud en cuanto su hijo esté inscrito. Los servicios incluyen:

- **Los Centros de Salud Basados en las Escuelas (SBHC):** capacidad para examinar el estatus de salud, diagnosticar y tratar muchas condiciones comunes, tales como la garganta irritada, dolores de cabeza, vacunas, infección de oídos, y otras enfermedades infecciosas como hepatitis, tuberculosis y enfermedades transmitidas sexualmente. La ley del Estado de Nebraska permite a los estudiantes elegir si quieren que se notifique a sus padres respecto a su atención médica con relación a infecciones transmitidas sexualmente. El SBHC no proveerá servicios de emergencia. El SBHC también proveerá servicios de conducta mental y psiquiátricos para niños y jóvenes. Los servicios pueden incluir el uso de tecnología "telehealth".
- **Servicios Dentales:** los servicios pueden incluir educación de salud oral, evaluaciones, aplicación de barniz de fluoruro, cuidado preventivo y limpieza, cuidado restaurativo/correctivo, y uso de tecnología "telehealth".

Los proveedores de servicios de salud basada en la escuela tratarán de coordinar el cuidado con el proveedor de cuidado principal, dentista y/o proveedor de salud de conducta de su hijo. Si usted tiene seguro médico privado o Medicaid los proveedores de los servicios de salud enviaran la cuenta a su seguro medico después de proveer los servicios. Si usted no tiene seguro medico actualmente, los proveedores de salud trabajará con las familias para ayudar a inscribir a su hijo(s) en Medicaid, si es elegible.

Compartiendo Información del Estudiante

OPS mantiene la información del estudiante en sus propios archivos y base de datos y en la Base de Datos Colaborativa de Omaha la cual es operada por "United Way of the Midlands". OPS permite que el personal que suministra servicios de salud tenga acceso a la información del estudiante de todas estas fuentes con el fin de proporcionar servicios de salud y para ayudar a evaluar el programa de servicios de salud basados en las escuelas y su impacto en el éxito estudiantil. OPS generalmente requiere del permiso de los padres para la entrega de información que no sea del directorio a menos que un estudiante visite un centro con una necesidad de salud y el padre aún no haya inscrito al estudiante; en tales casos se llamará al padre de familia rápidamente.

Consentimiento para Tratamiento y Liberación de Información

Para inscribir a su hijo en los servicios de salud basados en la escuela y para que OPS pueda liberar información confidencial al personal del proveedor para ayudar con el diagnóstico y tratamiento, se necesita un formulario de inscripción y consentimiento firmado en los expedientes de OPS y SBHC. El personal del SBHS por lo general intentará comunicarse con usted para informarle sobre la razón de la visita de su hijo y los servicios proporcionados. Al firmar este formulario de inscripción y consentimiento, usted da el consentimiento para lo siguiente:

- Yo autorizo al Centro de Salud Comunitario OneWorld y/o al Centro de Salud Charles Drew, UNMC, y/o Creighton a administrar exámenes y tratamientos a mi hijo con los servicios de salud basados en la escuela y entiendo que no se ha hecho ninguna garantía de los resultados de tales exámenes y tratamientos.
- En situaciones donde el personal entrenado de la escuela como la enfermera o auxiliares de salud no estén disponibles para dar medicamento recetado rutinario que se deba dar en la escuela, Yo autorizo al personal de SBHC a que administren tal medicamento a mi hijo.
- Yo autorizo a OPS y a su personal certificado, incluyendo a la enfermera escolar en la escuela de mi hijo, el "United Way of the Midlands" de parte de OPS, a entregar la siguiente información del estudiante al personal que suministra servicios de salud del SBHC identificados anteriormente para que el personal que suministra servicios de salud del SBHC proporcione servicios y dirija una evaluación del programa: Información de contactos de emergencia del niño(a), numero del estado del estudiante, asistencia y récords de disciplina, historial de vacunas, resultados de exámenes de salud tales como de audición y visión, evaluaciones psicológicas, récords de educación especial (IEP-MDT), Sección 504 del Plan de Adaptación, e información concerniente a la condición de salud tal como convulsiones y asma.
- Los estudiantes que salen de la escuela primaria y secundaria necesitan inscribirse de nuevo en el siguiente nivel escolar.
- Esta autorización expira cuando mi hijo(a) salga de la escuela primaria, secundaria, cuando salga del distrito o se gradúe.

Usted puede revocar esta autorización en cualquier momento entregando una carta a las Escuelas Públicas de Omaha, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024.

Firma del Padre/Madre/Tutor:	Relación con el niño:	Fecha:

Para el personal de la oficina solamente: ☐ Verified ☐ Programs ☐ Sections Initials

Charles Drew Center, Inc.

AUTHORIZATION FOR MEDICAL TREATMENT

Authorization for Medical Treatment: I do hereby acknowledge, agree and give my consent for diagnosis, treatment, therapy sessions, dental treatment, as deemed necessary by Charles Drew Health Center Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center Inc. facility will follow the instructions of my provider(s) in the position in said care.

Patient Care: I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.

Personal Valuables: I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center Inc. maintains no responsibility for property that is personal and in my possession.

Assignment of Benefits: I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Charles Drew Health Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/ Medicare and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.

Authorized Representative: I hereby authorize Charles Drew Health Center Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).

Statement of Responsibility: I understand that I am financially responsible to Charles Drew Health Center Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.

Authorization to Release Information to Insurance Company/Third Party Payer: I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. This Facility will endeavor to protect the confidentiality of my medical records. However, the Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed.

Non-covered Medicare/Medicaid Services: The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

Advanced Instructions for Healthcare: I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

Please Initial____ I acknowledge notification of Charles Drew Health Center Patient Rights and Responsibilities.
Please Initial____ I acknowledge notification of Charles Drew Health Center Inc. privacy practices.
*The undersigned certifies that he or she has read the foregoing, is the patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patients Signature/ Parent if Minor/Power of Attorney/ Guardian	Date
Responsible Party's Signature(If Not Same as Patient/Parent)	Insured's Signature
Witness to Signature	Patient Unable to Sign Consent Because

Patient/Student's Name (Please Print):

Patient/Student's Date of Birth:

CHARLES DREW COMMUNITY HEALTH CENTER, INC.

SCHOOL-BASED HEALTH CENTER
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Child name: _____ DOB: _____
Personal Representative name: _____
Address: _____ Phone: _____

As the personal representative of a child enrolled in the school-based health center operated by Charles Drew Health Center, Inc. ("Charles Drew"), I hereby authorize any physician, nurse practitioner, medical assistant or other health care staff of Charles Drew to furnish records and to discuss details of child's care and treatment at the school-based health center with certificated staff (school nurses, counselors, teachers, therapists, administrators) at Omaha Public Schools (OPS). I hereby authorize the School Based Health Center staff to furnish records regarding my child's care and treatment to my Primary Care Physician (PCP) _____. This authorization is to be ongoing until terminated by me or until my child is no longer enrolled in OPS. The purpose of the disclosure by Charles Drew is provide OPS certificated staff and my PCP with information about my child's health status, medications, treatments, and clinic visits which is important for my child's safety and to promote the health and educational success of my child.

I understand and acknowledge that:

1. Charles Drew may NOT condition my child's treatment, enrollment, or eligibility for benefits at the school-based health center on whether I sign this Authorization.
2. Medical information that is disclosed because of this Authorization may be subject to re-disclosure by the recipient and no longer protected by State Law
3. The authorization remains effective while my child is enrolled in the Omaha Public Schools. This authorization automatically expires when my child is no longer enrolled in the Omaha Public Schools.
4. I understand that I may revoke this Authorization at any time by giving written notice to the medical professional or medical assistant on duty at the school-based health center where my child receives services.
5. I understand that my revocation is not effective as to disclosures already made and actions already taken based upon this Authorization.
6. I have received a copy of this document.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effective as the original.

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____
Relationship to Patient if Signed by Personal Representative

Charles Drew Health Center, Inc.

NORTHWEST Health And Wellness CENTER 100% HEALTHY HUSKIES

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No

Northwest Health and Wellness Center Consent Form

Section 1: Patient Information

First name: _____ Last name: _____ Middle initial: _____

Social Security #: _____ Sex assigned at birth: _____ Birthdate: _____ Age: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Alt. Phone: _____

Does the student have a cell phone? ☐ No ☐ Yes: _____ May we text this #: ☐ No ☐ Yes

Emergency Contact: _____ Relationship to patient: _____ Phone: _____

Primary language spoken in the home: _____ Interpreter needed: ☐ No ☐ Yes

Please select one answer per question and provide additional information when required:

Are you a student?	☐ No	☐ Yes, which school: _____	
Are you a veteran?	☐ No	☐ Yes	
Are you a migrant farm worker?	☐ No	☐ Yes	☐ Seasonal
Are you Hispanic, Latino, or Chicano?	☐ No	☐ Yes	☐ Refuse to report

We must be able to contact you. Please check all ways we may contact you:

- ☐ Call home
- ☐ Call work
- ☐ Call home as "Heidi"
- ☐ Call cell phone
- ☐ Permission to leave message
- ☐ Mail at home
- ☐ Plain envelope
- ☐ Email
- ☐ Other - please specify: _____

Please check which of the following best describes your current housing. Please select only one:

- ☐ Living on the streets
- ☐ "Doubling Up" with family or friends
- ☐ Transitional housing
- ☐ Home-owner/Renting
- ☐ Rehabilitations facility
- ☐ Homeless shelter
- ☐ Public housing high rise or low rise
- ☐ Section 8 housing
- ☐ Other - please specify: _____

Please check which of the following best describes your race. Please select only one:

- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Pacific Islander
- ☐ More than one race
- ☐ American Indian or Native Alaskan
- ☐ Unknown, not listed, or refuse to report

Please check which of the following best describes your sexual orientation:

- ☐ Straight / Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Don't know
- ☐ Something else
- ☐ Choose not to disclose

Please check which of the following best describes your gender identity:

- ☐ Male
- ☐ Female
- ☐ Transgender male / female-to-male
- ☐ Transgender female / male-to-female
- ☐ Other
- ☐ Choose not to disclose

Please select one answer per question and provide additional information when required:

Is your student under the care of a medical specialist?	☐ No	☐ Yes, medical condition: _____ Name of specialist: _____
Has your student been hospitalized for any reason?	☐ No	☐ Yes, when: _____ What reason: _____
Allergies to medicine?	☐ No	☐ Yes, which medicines: _____
Allergies to foods?	☐ No	☐ Yes, which foods: _____
Is your student taking any medications?	☐ No	☐ Yes, name of medication: _____ Dosage of medication: _____ Name of medication: _____ Dosage of medication: _____

What pharmacy do you use: _____ Address: _____

Does your student or family have any of the follow medical conditions? Please check all that apply:

Asthma / Wheezing	☐ Student	☐ Family	High blood pressure	☐ Student	☐ Family
Allergies / Hay Fever	☐ Student	☐ Family	HIV / AIDS	☐ Student	☐ Family
ADHD / ADD	☐ Student	☐ Family	Hives	☐ Student	☐ Family
Anemia / Blood problems	☐ Student	☐ Family	Hyperactivity	☐ Student	☐ Family
Anaphylactic reaction	☐ Student	☐ Family	Joint Problems	☐ Student	☐ Family
Abnormal spinal curve	☐ Student	☐ Family	Kidney disease	☐ Student	☐ Family
Alcohol / Drug abuse	☐ Student	☐ Family	Lead poisoning	☐ Student	☐ Family
Acne	☐ Student	☐ Family	Learning problems	☐ Student	☐ Family
Behavior problems	☐ Student	☐ Family	Leukemia	☐ Student	☐ Family
Boys: testicle not in sac	☐ Student	☐ Family	Lumps in groin / breast	☐ Student	☐ Family
Broken bones	☐ Student	☐ Family	Muscle problems	☐ Student	☐ Family
Cancer	☐ Student	☐ Family	Nervous twitches / tics	☐ Student	☐ Family
Type of cancer: _____			Nose bleeds	☐ Student	☐ Family
Chicken Pox	☐ Student	☐ Family	Migraines	☐ Student	☐ Family
Diarrhea / Constipation	☐ Student	☐ Family	Seizure disorder	☐ Student	☐ Family
Chronic ear infections	☐ Student	☐ Family	Sickle cell disease	☐ Student	☐ Family
Concussion	☐ Student	☐ Family	Sinus trouble	☐ Student	☐ Family
Depression	☐ Student	☐ Family	Sleep problems	☐ Student	☐ Family
Diabetes	☐ Student	☐ Family	Snoring	☐ Student	☐ Family
Dizziness /Light-headed	☐ Student	☐ Family	Speech problems	☐ Student	☐ Family
Eczema / Skin infections	☐ Student	☐ Family	Stomach ulcers	☐ Student	☐ Family
Fainting with exercise	☐ Student	☐ Family	Suicide	☐ Student	☐ Family
Frequent headaches	☐ Student	☐ Family	Stroke	☐ Student	☐ Family
Frequent sore throat	☐ Student	☐ Family	Toothache / dental problems	☐ Student	☐ Family
Frequent stomach ache	☐ Student	☐ Family	Tuberculosis	☐ Student	☐ Family
High cholesterol	☐ Student	☐ Family	Underweight	☐ Student	☐ Family
Heart murmur	☐ Student	☐ Family	Urinary tract infections	☐ Student	☐ Family
Hearing loss	☐ Student	☐ Family	Vaginal discharge	☐ Student	☐ Family
Heart disease					

Please explain any checkmarks: _____

_____

_____

Section II: Immunization Consent

Under Federal Law, it is now required that parents sign specifically to authorize immunizations that their minor children/student(s) receive and parents must also receive written information about each immunization.

If your child/student receives immunizations at the School Based Health Center, your child/student will be bringing home written information about the immunizations that he/she will receive. If you have any questions about the written information on the immunizations, please feel free to call your School Based Health Center.

In order to avoid frequent visits to the School Health and Wellness Center to provide your signature for authorization, we have designed this form for you to give consent in advance, if you would like. By signing below, you give consent for your child/student to receive immunizations if he/she is due for them.

With my signature, I give consent for my child/student _____, to receive the following immunizations if he/she is due for any of them:

If you are unsure which immunizations your student will need, please consent for all by checking all of the boxes. We will only give those which are needed and required.

- ☐ TD / Tdap (tetanus booster)
- ☐ IPV (polio shot)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Varicella
- ☐ Prevnar
- ☐ Hib
- ☐ Dtap
- ☐ MMR (measles / mumps / rubella shot)

X _____ Date: _____
(Parent / Legal guardian signature)

The following vaccines are also available to support your student's health:

Influenza vaccine:

We are offering tow different forms of flu vaccines. To ensure your child/student gets the best option, please answer the following questions:

Does your child/student have an allergy to eggs or egg products that causes a serious reaction?	☐ No	☐ Yes
Has your child/student been diagnosed with Guillain-Bare Syndrome (GBS)?	☐ No	☐ Yes
Has your child/student ever had an allergic reaction to the flu vaccine in the past?	☐ No	☐ Yes
Does your child/student have asthma, diabetes, or another chronic illness?	☐ No	☐ Yes

Please check the type of vaccine you would like administered and sign below:

☐ Either Flu Shot (Inactivated Influenza Vaccine) or FluMist nasal spray (Live Intranasal Influenza Vaccine) at the provider's discretion as supplies permit.

Note: FluMist vaccine is not for children with diabetes, some children with Asthma, and other chronic medical conditions.

With my signature, I give consent for my child/student _____, to receive the Influenza (Flu) vaccine.

X _____ Date: _____
(Parent / Legal guardian signature)

Meningococcal vaccine:
The Meningococcal vaccine is recommended for adolescents and young adults to prevent bacterial meningitis, which is a serious infection of the fluid surrounding the brain, and may result in brain injury or death. This vaccine is often required for enrollment into college / university.

With my signature, I give consent for my child/student _____, to receive the Meningococcal vaccine.

X _____ Date: _____
(Parent / Legal guardian signature)

Gardasil and Gardasil 9, HPV vaccine:
The HPV vaccine is recommended for both ***males and females.*** Please review the following Frequently Asked Questions (FAQs) about Gardasil HPV vaccine from the Center for Disease Control and Prevention:

Why are HPV vaccines needed?
HPV vaccines prevent serious health problems, such as cervical cancer and other, less common cancers, which are caused by HPV (human papillomavirus). In addition, HPV can also cause other health problems, such as genital warts. HPV is a common virus that is easily spread by skin-to-skin contact during sexual activity with another person. It is possible to have HPV without knowing it, so it is possible to unknowingly spread HPV to another person. Safe, effective vaccines are available to protect females and males against some of the most common types of HPV and the health problems that the virus can cause.

Who should get HPV vaccine?
Gardasil, Gardasil 9 are licensed, safe, and effective for males and females. It is routinely given at 11 or 12 years of age, but it may be given beginning at the age 9 years through age 26 years. The CDC recommends that males and females may choose to get this vaccine to prevent genital warts, and anal cancer. It is important for students to get the HPV vaccine before their first sexual contact because they won't have been exposed to HPV.

With my signature, I give consent for my child/student _____, to receive the Gardasil vaccine.

X _____ Date: _____
(Parent / Legal guardian signature)

Section III: Financially Responsible Party Information

Please complete this section for hte parent or guardian that is responsible for paying medical expenses.

First name: _____ Last name: _____ Middle initial: _____

Relationship to patient: _____ Birthdate: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____ Alt. Phone: _____

Responsible Party's Social Security #: _____ Responsible Party's Drivers License #: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Section IV: Patient's Household Information

Is the patient the head-of-household? ☐ No ☐ Yes

Is the head-of-household the same as the financially responsible person? ☐ No ☐ Yes

Please ***circle*** your family size and annual household income range (should be in the same row).

Family Size:	Annual Income Ranges:					
1	$0-12,060	$12,061-15,075	$15,076-18,090	$18,091-21,105	$21,106-24,120	Over $24,120
2	$0-16,240	$16,241-20,300	$20,301-24,360	$24,361-28,420	$28,421-32,480	Over $32,480
3	$0-20,420	$20,421-25,525	$25,526-30,630	$30,631-35,735	$35,736-40,840	Over $40,840
4	$0-24,600	$24,601-30,750	$30,751-36,900	$36,901-43,050	$43,051-49,200	Over $49,200
5	$0-28,780	$28,781-35,975	$35,976-43,170	$43,170-50,365	$50,366-57,560	Over $57,560
6	$0-32,960	$32,961-41,200	$41,201-49,440	$49,441-57,680	$57,681-65,920	Over $65,920
7	$0-37,140	$37,141-46,425	$46,426-55,710	$55,711-64,995	$64,995-74,280	Over $74,280
8	$0-41,320	$41,321-51,560	$51,561-61,980	$61,981-72,310	$72,311-82,640	Over $82,640

**For patients who would like to apply for sliding fee scale discounts, actual income will be verified.*

I authorize the release of information regarding continuation of care and / or any payment for services. I authorize a copy of this document may be used as the original document. I certify that all information provided is true and accurate to the best of my knowledge.

X _____ Date: _____
(Parent / Legal guardian signature)