

## SCHOOL-BASED HEALTH PROGRAM CONSENT FOR TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Adena Local School District** (“District”) and Adena Health System (“AHS”) are partnering to offer a school-based health program to District students (the “Program”). The goal of the Program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the Program is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. Although we are happy to fill the need of a Primary Care Provider, you are not required to transfer your care to AHS prior to or after being seen. The District will still provide school nursing and emergency services as always whether you consent to participate in this program or not.

### Patient / Student Information:

Patient/Student, First and Last Name		Parent/Legal Guardian, First and Last Name	
Street Address	City	State	Zip Code
Phone Number	Date of Birth (Month-Day-Year)	School & Grade Level	
Primary Care Provider		Primary Care Provider’s Phone Number	
Primary Care Provider’s Street Address	City	State	Zip Code

### Consent for Medical Care/Treatment:

I wish to have <b>ALL</b> applicable services / treatments available for the above referenced patient/student.			
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> (If no, make selections of services/treatments you do consent to have available below)			
	Care and treatment for any injury/illness		Pregnancy Testing
	Mental/Behavioral Health Treatment		Birth Control
	Physical Examinations / well-child (i.e. sports, work, school) <b>Note:</b> Well-child includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate		

### Consent for Vaccinations:

I wish to have <b>ALL</b> vaccines available for the above referenced patient/student.			
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> (If no, make selections of vaccines you do consent to have available below)			
<b>Required Vaccines*</b> for School Attendance in Ohio		<b>Recommended Vaccines* but not required by the Ohio Department of Health</b>	
	DTaP / Tdap / Td		Influenza (flu)
	Meningococcal / Men B		Human Papilloma Virus (HPV)
	Measles Mumps Rubella (MMR)		Hepatitis A

	Varicella		Pneumococcal
	Polio		Hib
	Hepatitis B	*Age appropriate, following the American Academy of Pediatrics vaccination schedule	

**Authorization to Release Medical Information**

I authorize AHS and District to share/release/exchange my/my child’s health information with each other, including, but not limited to, information regarding services provided to me/my child at school and/or in the Program, for treatment and care coordination purposes.

YES  NO

There are a few instances in which we can provide treatment and/or testing to your minor child without parent/legal guardians consent under Ohio law. Provided below are those instances:

- STD testing and treatment, \*HIV/AIDS is limited to testing only
- Drug or alcohol abuse and treatment
- Mental health services if 14 years or older and only for a limited period of time, \*not including medication.
- Sexual assault examination

Although minors may be able to consent to the above treatment, this doesn’t mean it will be kept confidential. Medical Records, with limited exceptions, may still be obtained by the parent/guardian and the child’s insurance on record will still be billed.

By signing this consent, I am authorizing AHS to provide the services to my minor child outlined in this form and to bill me/my insurance for any services rendered to my child at AHS. I understand that this consent for treatment will remain valid until my child is no longer enrolled in District, unless I revoke or makes changes sooner. I understand that I may make changes at any time to this consent or revoke it entirely by making a written request to AHS. I understand that even if I revoke my consent, as a parent of a minor child, my minor child may still consent to the treatment for which they are allowed to by law as described above. I have reviewed this consent and understand the services available. It is my responsibility to tell AHS about changes in insurance coverage or changes to my child’s health condition(s), immunization records, or medications. I further understand that, by signing below, I am authorizing AHS and District to share my/my child’s medical information with each other for the purposes of treatment and care coordination. Additionally, I authorize AHS to request medical records/information from any health care provider or facility where my child has been seen and to send results of any treatment to my child’s regular doctor/clinic. Furthermore, by signing below I am attesting that I am the parent/legal guardian of the above-named child and understand that a new consent form must be signed by a legal guardian if this would change. Finally, I understand that if I am not this child’s birth parent that I must provide documentation or an explanation of my ability to sign this consent on behalf of the minor child and have attached such documentation to this consent.

\_\_\_\_\_  
**Parent/Legal Guardian *Printed* Name**  
**(If student is less than 18)**

\_\_\_\_\_  
**Parent/Legal Guardian *Signature*      Date/Time**

\_\_\_\_\_  
**Student *Printed* Name (if student is 18+)**

\_\_\_\_\_  
**Student *Signature*      Date/Time**