

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

Zane Trace 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

