Valley Health Care School Based Health Clinic
Parental Consent Form (Grades PK-12)

If you have questions about this form, the services we provide or would like help completing this form please call our SBHC Cell Phones at (304)-614-5473 or (304)-642-4565 to speak with one of our School Based Health Clinic staff.

Brochure Information
Valley Health Care, Inc. and the Randolph County Board of Education have partnered to bring School-Based Health to your child's school. At your School-Based Health Center, there are licensed healthcare clinicians to provide on-site medical care. School-Based Health Centers have been shown to improve both health and academics, reduce absenteeism and increase access. With enrollment, your child can be seen at the School-Based Health Center quickly and without you having to leave home, take off time from work, or find a ride. Our goal is to offer convenient, comprehensive care to your child in conjunction with your child's regular primary care provider (PCP).

Some examples of the services we can provide are:
- Well Child Visits
- Treatment for acute illnesses such as the flu, strep throat, etc.
- Treatment for chronic illnesses such as asthma, diabetes, etc.
- Vaccinations
- Sports Physicals
- Referrals to specialists (i.e. ENT referrals, etc), orders for X-Rays, Lab Work, etc.

Insurance Information

- Some of the services performed at our School-Based Health Clinic will be billed to your insurance. If you would like for your child to have access to our services, please provide your insurance information. There is a section for this in our consent packet. You will be billed for your co-pay if you have one. We accept most major insurances, including Medicaid.
- If your child does not have insurance, please contact VHC for assistance in enrolling in an insurance plan or the VHC's Sliding Fee Discount Program

STUDENT INFORMATION

Student's Last Name:_____

Student's First Name: _____

Date of Birth:
_____/_____/_____
Month Day Year

Student's Social Security Number: _____

Gender: ❑ Male ❑ Female ❑Trans

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Race: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address:
_____

_____ ____ _____
City State Zip Code

Student's Grade: _____
Homeroom Teacher: _____

Who is the student's regular doctor?

Name: _____

Prefered Pharmacy:_____

Does the student/patient see a counselor or have Behavioral Health Services: ___Yes ___No

Provider/Agencies Name:_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____First Name: _____

Father
Last Name: _____First Name: _____

Legal Guardian (If Applicable)

Last Name: _____First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for Parent or Guardian

Home Tel: _____ Work Tel: _____

Mobile: _____Consent to Text: ❑

Email:_____

Additional Emergency Contact(s)
Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have CHIP?

❑ No ❑ Yes: CHIP # _____

If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a WV State approved low-income health insurance plan?

❑ No ❑ Yes

Does your child have other insurance?

❑ No ❑ Yes: Name: _____

Coverage Number: _____

Policy Holder's Last Name: _____

Policy Holder's First Name: _____

Relationship to Patient: _____

Date of Birth: _____/_____/_____
Month Day Year

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of Valley Health Care, Inc. as part of the school health program. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision, hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for Strep throat, Flu, Urinary Tract Infections, anemia, sickle cell, and diabetes, etc.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Dental sealants where available.
8. Referrals for service not provided at the School-based health center.
9. Annual health questionnaire/survey.

I have read and understand the services listed and my signature provides consent for my child to receive services provided by the Valley Health Care, Inc. School-Based Health Center.

NOTE: Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated.

X _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)*

Date _____

Valley Health Care, Inc.

FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Board of Education of Randolph County, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the Valley Health Care, Inc. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the Valley Health Care Inc. School-Based Health Center to release specific medical information of the student named on the reverse page to the Randolph County WV Board of Education.

I consent to the release from Valley Health Care, Inc. to the Randolph County WV Board of Education and from the Randolph County WV Board of Education to Valley Health Care, Inc., of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law.

My signature on this form also gives my consent to Valley Health Care, Inc. to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed
To: Date that student is no longer enrolled in the SBHC

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)*

Date _____

Medication Allergies

Is the Student/Patient allergic to or has had a reaction to:	Yes	No		Yes	No
Any foods (including lactose intolerance)	☐	☐	Local anesthetics (including lidocaine)	☐	☐
Any medicines (Penicillin or other antibiotic)	☐	☐	Latex	☐	☐
Please explain any allergies:					

	Yes	No		Yes	No
Has there been any change in the student/patient's health during the past year?	☐	☐	Has the student/patient seen an eye doctor in the last year?	☐	☐
Has the student/patient had any serious or sports related injuries?	☐	☐	Are any of the student/patient's teeth causing him/her pain?	☐	☐
Has the student/patient ever been hospitalized overnight? If yes, date(s) of hospitalization(s):	☐	☐	Has the student/patient had a dental cleaning in the last six months?	☐	☐
Has the student/patient had any surgery in the past?	☐	☐	Does the student/patient smoke?	☐	☐
Does the student/patient have any heart problems, such as heart murmur or congenital defect?	☐	☐	Is the student pregnant or possibly pregnant?	☐	☐
	☐	☐	Is the student/patient nursing?	☐	☐
Please explain any "Yes" answers:					
Is there anything else that you think our staff should know before treating the student/patient?					

CONDITION	Yes	No		Yes	No
Anemia or blood disorders	☐	☐	Mononucleosis	☐	☐
Asthma	☐	☐	Overweight/obesity	☐	☐
Autism (Mild or Severe)	☐	☐	Pneumonia	☐	☐
Bladder or Kidney infections	☐	☐	Rheumatic fever or heart disease	☐	☐
Chicken Pox	☐	☐	Seizures	☐	☐
Eating Issues	☐	☐	Sleep Issues	☐	☐
Headaches/migraines	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Ulcer/digestive problems	☐	☐
Learning/Developmental Disabilities	☐	☐		☐	☐
Other health concerns:					

The Health Center has my permission to give my child the following over-the-counter medications at the discretion of the medical provider. Please check.

	Yes	No		Yes	No
Tylenol	☐	☐	Ibuprofen	☐	☐
Cough Drops	☐	☐	Tums/Maalox	☐	☐
Cough Syrup	☐	☐	Zofran	☐	☐
Mucinex	☐	☐	Zyrtec or Claritin	☐	☐
Hydrocortisone Cream	☐	☐	Benadryl	☐	☐
Orajel	☐	☐	ALbuterol (breathing treatment)	☐	☐

Social History

Caffeine intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Vegan ☐ Gluten free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic ☐Other_____

Functioning smoke alarms in home: ☐ Yes ☐ No

Sunscreen use: ☐ Always ☐ Sometimes ☐ Never

Live alone or with others? ☐ Alone ☐With Others

Are you currently taking any prescription and/or non-prescription medications? These include vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, or cold medications? Please list any prescription or over the counter medications below.

NAME OF MEDICATION	DOSE	FREQUENCY

Family History

Illness/Condition	Family Members						Describe
	Grandmother	Grandfather	Father	Mother	Brothers	Sisters	
Heart Disease							
Diabetes							
Stroke/TIA							
High Blood Pressure							
High Cholesterol or Triglycerides							
Liver Disease							
Alcohol or Drug Abuse							
Anxiety, Depression or Psychiatric Illness							
Tuberculosis							
Anesthesia Complications							
Genetic Disorder							
Cancer (describe the type of cancer for each person)							
Other – describe							
Other – describe							

Place a check mark (√) in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Check “NONE” if you are not aware of any relative having the illness/condition. Describe the illness or condition.