Jefferson School Based Health Centers

General Consent For Services

I give permission to Jefferson School Based Health Center (SBHC) to perform such medical and therapeutic procedures as may be professionally necessary or advisable for me (or my child's) health screening, diagnosis and treatment. I understand that a patient record will exist for each student. This consent allows services and information to be authorized and shared between Jefferson Healthcare, Jefferson County Public Health and Discovery Behavioral Health within the clinic.

I understand the following types of services are offered through the School Based Health Clinic (SBHC):

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Laboratory tests
- Reproductive health services, e.g. counseling, education, exams, and referrals
- Immunizations
- Health education, counseling, and wellness promotion
- Nutrition and health education, wellness counseling

Services provided at Jefferson SBHC must have a signed consent form from a parent or legal guardian before health services are provided to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. According to the law, minors may provide their own consent for alcohol and drug treatment and mental health treatment at age 13 or older and reproductive health care at any age. If necessary, the SBHC will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

The student's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), alcohol and drug treatment, or mental health counseling.

When a person consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- If the client gives us permission through a signed release of information.
- If student shows risk of suicidal behavior.
- If student plans to do serious bodily harm to another person.
- If student has a life threatening health problem **and is under 18 years of age.**

All information and services received are confidential.

The School Based Health Center encourages all students to involve their parents or guardians in their health care decisions whenever possible.

This consent expires when the student is no longer enrolled in the Port Townsend or Chimacum School District.

___________________________________ ____________________________ ______________

Student Name Student Signature Date

___________________________________ ____________________________

Parent or Legal Guardian Name (Please Print) Relationship to Student

______________________________________ _________________

Parent or Legal Guardian Signature Date

____ Please initial here to give consent to release SCAT 3 (baseline concussion assessment) to school and primary care provider.

Please turn over and complete Registration Form on back

Student's Information

First Name: ______________________________

Last Name: ______________________________

Date of Birth: __________ Grade: __________

Student's Identifying Gender: ______________

Phone Number: __________________________

Address: ________________________________

______________________ ___ ________

City State Zip Code

Please check which best describes the student's race:

- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Spanish/Hispanic/Latino
- ☐ Pacific Islander
- ☐ White
- ☐ Multi-Racial

Medical/Mental Health History:

Student's Primary Physician/Provider: ____________________

Medical and or Mental Health Concerns: ____________________

____

Does the student need medication on regular basis? If yes, please list:

____

Allergies to Medications: ______________________________

List any: surgeries, serious illnesses, ongoing illnesses, injuries: _______

____

Insurance Information:

Does the student have health insurance: ☐ No ☐ Yes

Plan Type: ☐ Medicaid/Apple Health ☐ Private Insurance

Insurance/Plan Name: ________________________

Policy Number: ____________________________

Group Number: ____________________________

Subscriber Name: ___________________________

Subscriber Date of Birth: _____________________

Subscriber's Relationship to Student: ______________

Parent/Guardian Information

First Name: ______________________________

Last Name: ______________________________

Relationship to Student: ____________________

Phone Number: ____________________________

Alternate Phone Number: ____________________

Emergency Contact:

Name: __________________________________

Phone Number: ____________________________

Relationship to Student: ____________________

Student/Family Health History: (please check all that apply)

☐ Asthma ☐ Diabetes ☐ Heart Problems/Stroke ☐ Cancer

☐ Seizures ☐ High Blood Pressure ☐ High Cholesterol ☐ Mental Health

☐ Alcohol or Chemical Abuse ☐ Died Before Age 50

Explanations: (if necessary) ______________________

____

____

Fees and Billing:

No one will be denied services due to inability to pay, but the following information is required so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information, we will bill you at full fee for service.

Sliding Fee Scale:

If the student does not have insurance and does not qualify for Apple Health we can provide sliding fee scale for certain services. Please state GROSS monthly income $__________ # of Family Members ___

Consent to Release Information to Insurance Carrier: I certify the information supplied above is accurate. I authorize release of medical and related information to my health insurance company or other third party payer for the purpose of obtaining payment for services rendered. Policies are in place to assure privacy is maintained related to confidential services.

Signature: ________________________ Date:__________ Relationship to Student: ______________