

SCHOOL BASED MEDICAL/DENTAL TREATMENT CONSENT FORM

Affinia Healthcare School Based Teams can provide medical and dental services at your child's school. Your child's participation is voluntary. **In order for your child to receive services; you must provide all information requested below.**

Demographics

Child's Last Name: _____		First Name: _____		Middle Initial: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth ____/____/____		Social Security #: _____ - ____ - ____	
Home Address: _____				Zip: _____
School: _____				Grade: _____
Parent/Guardian Name (please print): _____			Relationship: _____	
Cell Phone #: (____) _____ - _____	Home Phone #: (____) _____ - _____	Work Phone #: (____) _____ - _____		
Email Address: _____			Language spoken at home: _____	
Emergency Contact: _____			Relationship: _____	
Phone #: (____) _____ - _____				

Family Information

Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino				
Race: <input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American		
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White			
Does your family participate in a Housing Assistance Program?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Decline to report
<input type="checkbox"/> Public Housing	<input type="checkbox"/> Housing Voucher Program	<input type="checkbox"/> Subsidized Housing	<input type="checkbox"/> Other	
Does your family live in a Homeless Shelter or without housing at this time?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Decline to report

Health History: Please check any history of/or difficulty with any of the following

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Disorder	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections (frequent)	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Back Problems/Scoliosis	<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Physical Problems
<input type="checkbox"/> Behavioral Issues	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eye/Vision Problems	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Headaches (frequent)	<input type="checkbox"/> Liver Disorder	NONE OF THESE LISTED

Allergies, please describe type: Food _____ Latex _____
 Medication _____ Seasonal _____ Other _____

Describe type of reaction: _____

Hospitalization date(s), please describe problem: _____

Surgery date(s), please list reason for surgery: _____

Please explain any item checked above: _____

Please list any medications your child is taking: _____

Any other concerns or comments: _____

Child's Last Name: _____	First Name: _____	Date of Birth ____/____/____
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Insurance

Does your child have a medical doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time your child saw his/her doctor for a physical or well child exam?
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(Provider/Clinic): _____	Date: ____/____/____
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Preferred Pharmacy (If M.D. or Nurse Practitioner feels your child would benefit from medications):

Pharmacy Name: _____	Location: _____	Phone: (____) ____-_____
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Does your child have health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medicaid/ MO Health Net Plan #: _____
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Other Health Insurance, Plan Name and #: _____
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Eligible Affinia Healthcare School Based Services

Medical Services: This service may include completing pediatric comprehensive medical histories or physical examinations, sports physicals, immunizations, or vision and hearing screenings, providing referrals for dental or specialty care, diagnosing and treating acute and chronic medical problems, writing prescriptions for medications, ordering laboratory tests, interpreting test results. In addition, comprehensive reproductive services may also be provided including contraception and education (pills, patch, ring, depo provera, and nexplanon implant; no IUDs).

Behavioral Health Education: This service may include educating and/or counseling students on nutrition and exercise, sexuality and reproductive health, preventative health care and social issues such as problem solving, conflict resolution, dating relationships, life skills, and substance abuse.

Total Dental Care: This service may include Affinia Healthcare affiliated general dentists providing total dental care and oral hygiene instructions for the student which may include dental exams, x-rays, cleanings, fluoride varnish, fillings, crowns, extractions. Parents and legal guardians will be contacted regarding any follow-up treatment needed and the necessary consent to perform. Access to dental providers will be granted for any additional questions.

* (All patients requiring an extraction will be given a second consent form for permission).

***Please Note, this consent is valid for 4 years**

I give permission for Affinia Healthcare School Based Team to provide services for my child. I verify, I have read the information regarding the notice of Privacy Practices (HIPAA).

I give consent for Affinia Healthcare to use and disclose my child's health information to people involved in my child's care, also including my child's regular doctor and school nurse. (Students may request that certain visits and information, as allowed by Missouri law, remain "confidential" so that their parent/guardians would not have access to that particular information without the student's written consent.)

I give consent for payment of authorized insurance carriers to be made on my behalf of Affinia Healthcare for any services furnished to my child.

Parent/Legal Guardian Name (print): _____	Date: _____
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Parent/Legal Guardian (signature): _____	Date: _____
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Provider Review (signature): _____	Date: _____
Support Staff Review (initial/date): _____ / _____ / _____	

Affinia Healthcare
1717 Biddle Street
St. Louis, MO 63106

Notice of Privacy Practices **Written Acknowledgement Form**

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our *Notice of Privacy Practices* states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our right to change our *Notice of Privacy Practices*
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures
- The person to contact for further information about our privacy practices

**I have been informed of Affinia Healthcare's *Notice of Privacy Practices*.
I am aware that I have a right to receive a written copy of Affinia Healthcare's
Notice of Privacy Practices upon request.**

DOB: _____

Print: Full Name of Patient

Medical Record #

Signature of Patient/Guardian/Legal Representative

Date

Print: Name of Guardian/Representative

Title/Relationship

Print: Witness

Title

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____

DATE _____

FORM REVIEWED BY _____

DATE _____

Did you bring your immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.