Affinia Healthcare
1717 Biddle Street • St. Louis, Missouri 63106
Main Number: 314-898-1700 • www.affiniahealthcare.org

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: □Male □Female □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: □ Hispanic or Latino □ Non Hispanic or Latino			
Race: □ American Indian or Alaskan Native	□ Asian	□ Black or African American	
□ Native Hawaiian or Other Pacific Islander	□ White		

Does your family participate in a Housing Assistance Program?	□Yes	□No	□ Decline to report	
□Public Housing	□ Housing Voucher Program	□ Subsidized Housing	□Other	
Does your family live in a Homeless Shelter or without housing at this time?	□Yes	□ No	□ Decline to report	

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

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

Allergies, please describe type: □ **Food**_____ □ **Latex**_____ □ **No Allergies**
□**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 _____

Insurance

Does your child have a medical doctor?	□**Yes**	□**No**	If yes, when was the last time your child saw his/her doctor for a physical or well child exam?
(Provider/Clinic):_____			Date:_____

Preferred Pharmacy (If M.D. or Nurse Practitioner feels your child would benefit from medications):		
Pharmacy Name:_____	Location: _____	Phone:_____

Does your child have health insurance?	□**Yes**	☑**No**	Medicaid/ MO Health Net Plan #:_____
Other Health Insurance, Plan Name and #:_____			

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:

□ I am interested in Affinia HealthCare affiliated general dentists providing total dental care services which may include preventive care, fillings, crowns, baby teeth root canals, extractions. When an exam is performed and cavities/issues are found, Affinia HealthCare will contact me indicating all cavities/issues found, the treatment needed and consent to perform only as needed as stated above.

□ If *you **do not** consent for certain portion of the dental treatment, please indicate which service(s) you would like excluded:*_____

* (Children requiring an extraction will be given a second consent form (tooth number) for permission).

Preventive Dental Care Only:

□ I understand and give consent to the Affinia HealthCare dentists to provide child dental care which will ONLY include **dental exams, x-rays, cleanings, fluoride varnish, sealants at school without my presence unless I withdraw this consent.** I understand my child will NOT receive **fillings, crowns, extractions, baby root canals or spacers.** If *you **do not** consent for a certain portion of the dental treatment, please indicate which service(s) you would like excluded:*_____

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:**_____
Parent/Legal Guardian (signature):_____	**Date:**_____

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?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

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.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (4/17)