CHRISTUS School Based Clinics

INFORMED CONSENT FOR TREATMENT AND PREVENTATIVE HEALTH CARE SERVICES

CHRISTUS Provider Network will offer health care services to your children through the CHRISTUS School Based Clinics. Services are not to replace the traditional services provided by the school nurse, but rather to provide a program offering more comprehensive examinations and treatment to promote wellness. Services available include:

1. Immunizations
2. Physical exams
3. Health education and prevention
4. Social Services referral assistance
5. Sports Physicals
6. Treatment of acute minor injury and illness
7. Counseling referrals for emotional and psychological disorders

Please note: Primary health care services are available to students by a full time licensed and certified physician assistant or nurse practitioner. Services are optional and at no cost to the students. If you do want your child to receive these services, he/she may still receive traditional school health services from the school nurse (where available).

Please Read Carefully and Complete the Consent Form Below To Allow Your Child To Be Treated At The Clinic

School Name: _____Grade:_____ Male or Female (circle one) Ethnicity (data purposes only):_____

Student Name_____ _____ Date of Birth_____
(Please Print) Last First MI (MM/DD/YY)

Address_____
Street City State Zip Code

Parent/Guardian Name: _____
(Please Print) Last First MI

Home Phone (_____) _____ Cell Phone (_____) _____
Please Print Name if # belongs to Someone Else

Work Phone (_____) _____ Email _____

Parent/Guardian Name: _____
(Please Print) Last First MI

Home Phone (_____) _____ Cell Phone (_____)_____

Work Phone (_____) _____ Email_____
Please Print Name if # belongs to Someone Else

I authorize a physician or his/her delegate (physician assistant or nurse practitioner) to provide the necessary and/or advisable treatment for my child. I give my permission for medical evaluation and management, treatment and/or procedures for my son/daughter's medical condition within the capabilities of the facility and its personnel. I agree to completely disclose all known allergies, chronic illnesses, prior medication or drug adverse reactions and any current medications. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice. My child and I may be asked to complete a survey in order to measure and improve clinic services.

Signed: _____ Date_____
Parent or Guardian (Please Circle One)

☐ May we share medical information with Texas Children's Physician Assistant/Nurse Practitioner working in the clinic? (For Yellowstone Academy Students only)

Allergies to Medications: _____

Current Medications: _____

Past medical history: _____

Does student have a physician (PCP):____Yes ____No? If so, Name: _____

All services within the center are provided at no cost to the student or family. However, we can better serve your overall needs if we know whether your child has health insurance.

____Medicaid _____CHIP _____Private Health INS _____None

CHRISTUS SCHOOL BASED HEALTH CENTER
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information may be disclosed to		**The following information may be released to school personnel**
☐ Principal	☐ School Counselor	☐ Clinically pertinent information
☐ Assistant Principal	☐ School Nurse	☐ Progress notes
☐ Classroom Teacher	☐ Teacher Aide	☐ History and physical exam
☐ Registrar	☐ Secretary	☐ Immunizations
☐ Primary Care Physician		☐ Consultation reports
☐ Other (specify)		

Signature of patient or personal representative who may request disclosure
I understand that I do not have to sign this authorization, however my treatment for service may be denied if I do not sign this form unless specified above under Information may be disclosed. I can inspect or copy the protected health information to be used or disclosed.
I authorize CHRISTUS School Based Clinics to release the protected health information specified above.

By signing this Authorization you acknowledge and agree that CHRISTUS School Based Clinic may use or disclose personal health information for the purpose (s) of medical treatment and/or referrals.

Right to revoke authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at CHRISTUS School Based Clinics. (Nurse Practitioner)

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature: _____Date: _____

Authority to sign if not patient: (circle) Parent or Legal Guardian