

Consent for Athletic Well-Child Exam Health Services and Treatment

SBHC Health Services Provider

Anacostia SHS Ballou SHS Cardozo EC Coolidge SHS Dunbar SHS Woodson SHS Roosevelt SHS

DCPS School of Enrollment

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p>Student's Last Name: _____</p> <p>Student's First Name: _____</p> <p>Date of Birth: ____/____/____ <i>Month Day Year</i></p> <p>Student's Social Security Number: ____-____-____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Grade _____</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>Student Address: _____ _____</p> <p>Who is or will be the student's regular doctor? Name: _____ Telephone: _____ Address: _____</p>	<p>Mother Last Name: _____ First Name: _____</p> <p>Father Last Name: _____ First Name: _____</p> <p>Legal Guardian, if applicable Last Name: _____ First Name: _____ Relationship of legal guardian to student <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or Uncle <input type="checkbox"/> Other: _____</p> <p>Contact information for parent or guardian Home Tel: _____ Work Tel: _____ Cell: _____</p> <p>Additional Emergency Contact Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____</p>

INSURANCE INFORMATION

<p>Does your child have Medicaid coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes: Medicaid ID #: _____</p> <p>Which Plan? <input type="checkbox"/> AmeriHealth Caritas DC <input type="checkbox"/> MedStar Family Choice DC <input type="checkbox"/> Health Services for Children with Special Health Care Needs (HSCSN) <input type="checkbox"/> CareFirst Community Health Plan DC</p>	<p>Does your child have coverage through your employer or any other type of health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes, Health Plan: _____ Member ID/Policy Number: _____ Health Insurance Phone: _____</p> <p>If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the licensed health professionals at the School-Based Health Center as part of the school health program approved by the District of Columbia Department of Health (DC Health) and the District of Columbia Public Schools (DCPS.) I understand that the school-based health center will ensure confidentiality in accordance with the law, and that students 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. School health services, including screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
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. Reproductive health care services, including abstinence counseling, providing access to birth control, pregnancy testing, STD screening and treatment, HIV testing, PAP smears when indicated, and referrals for abnormal results, as age appropriate.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
8. Dental treatment consisting of examinations, x-rays, diagnosis & treatment modalities that may include cleaning, administration of topical and local anesthesia, fillings and sealants.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

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PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature below authorizes release of health information obtained by the School Based Health Center to DC Public Schools and DC Health. This information may be protected from disclosure by federal privacy law and District law. I am further authorizing the School-Based Health Center to release specific medical information to DC Public Schools and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation. I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient, who shall provide written notification to the receiving party that this health information is being re-disclosed for the specific stated purpose, and that any additional re-disclosure will require additional consent.

I authorize the School-Based Health Center to release specific medical information of the student named on the reverse page to the DC Public Schools and DC Health.

I understand that the results of reportable diseases and immunizations administered will be released to DC Health and the DC Public Schools. In addition, case records and survey information may be used for program evaluation in accordance with Federal and District laws regarding patient confidentiality.

My signature in the Consent for Release of Health Information section below gives my consent to the School- Based Health Center to contact other providers who have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page **To:** Date that student is no longer enrolled in sports activities with DCPS

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

YES: I have read and understand the services listed on the previous page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the selected school-based health center for well-child exam and sports clearance as long as my child is participating in DCPS sports activities. To promote continuity of care my child will only be enrolled at ONE SBHC. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In accordance with the Minor's Health Consent Regulation (22-B DCMR 600), parental consent is not required for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Parental consent is also not required for vaccination of minors 11 years and older who meet the informed consent standard, when the vaccination is recommended by the United States Advisory Committee on Immunization Practices (ACIP) and is provided in accordance with the ACIP's recommended immunization schedule.. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered. Parental consent is not required for students who are 18 years or older or for legally emancipated students.

I hereby acknowledge and agree that, as provided for in D.C. Official Code sec. 38-651.11, the District, the school, its employees and agents, which shall include the practicing physician, physician assistant or advanced practice nurse, shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code sec. 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form must be completed and submitted before the student can receive health services.

NO: I do not give permission for my child to receive SBHC services.

X

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

Date

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

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



Consent to Share Student Health Educational Records

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. The purpose of this consent is to allow key school-based staff members (*such as the principal, school nurse, nurse case managers, 504 Coordinators, and Special Education staff members*) who work with your child to share health-related educational records with external health-related agencies and healthcare providers, including school-based health centers (*if there is one located in your school*). These staff members and health care providers would then be able to better coordinate health-related services for your child. Coordinated services will better ensure that your child’s needs are met, and that he/she can fully participate in the school’s learning environment. **IF YOU AGREE TO THIS CONSENT, PLEASE COMPLETE, SIGN AND RETURN IT TO THE REGISTRAR AT YOUR CHILD’S SCHOOL.**

_____	_____	_____
(Student/Child’s Name)	(School Name)	(Date of Birth)
_____	_____	
(Grade)	(Student ID, if known)	

1. I authorize the District of Columbia Public Schools to share the educational records regarding my child specified in Section 3 below with each of the following agencies and organizations:

- *DC Department of Health,
- *DC Department of Mental Health,
- *DC Department of Health Care Finance,
- *DC Department of Human Services,
- *Your child’s health care provider(s), and
- *Other health service providers who deliver services in the school

2. I understand that this information may be used ONLY for the following purposes:

- * Planning and providing coordinated educational and health related services, and
- * Evaluating programs serving my child and the services provided to my child.

3. I authorize the use/disclosure of each of the following records:

- *School nurse records,
- * IFSP/IEP documents,
- * 504 Plans,
- * Class schedule,
- * Attendance records,
- * Grades, observations and other educational information contained in student records,
- * Current Medication orders (retained by the school nurse),
- * Eye medical reports,
- *Audiology reports, and
- *Nursing care plan (as part of IEP or 504 Plan)

4. I understand that:

- * This authorization is voluntary and my child will not be refused educational services if I choose not to sign it, and
- * I have the right to request a copy of this form after I sign it and to see or copy any information disclosed under this consent.

5. I consent to the use/disclosure of the above information. I understand that this information may not be used for any purposes other than those stated above in Section 2. This consent may be revoked in writing by me at any time. I understand that revoking this authorization will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

_____	_____	_____
(Signature of parent/guardian/student over 18)	(Relationship to the student)	(Date)

This authorization expires one year from the signature date above.

**GEORGETOWN UNIVERSITY HOSPITAL
 CONSENT FOR TREATMENT, RELEASES, ACKNOWLEDGEMENTS AND
 FINANCIAL AGREEMENT**

By my signature on the front of this form, I agree that I:

1. **General Consent for Treatment.** Voluntarily consent to and authorize such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications ("Treatments"), by employees and authorized agents of Georgetown University Hospital ("Hospital") as may be considered necessary or advisable in their professional judgment, and may include the drawing and testing for HIV (the virus that causes AIDS) and other blood borne diseases. I further acknowledge that no guarantees have been made regarding the effect of such Treatments on any medical condition.
2. **Right to Refuse Treatments.** Understand that I have the right to make informed decisions regarding all care and Treatments, and that I should ask my health care professionals to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments that I do not want.
3. **Assignment of Benefits / Financial Responsibility.** Authorize and Assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to the Hospital for services rendered. I further assign the proceeds of any settlements, judgments or verdicts from third party liability claims for injuries treated by the Hospital to the Hospital in an amount equal to the outstanding balance of all charges due and owing. I agree that any excess payments may be applied by Hospital to satisfy any outstanding accounts resulting from prior admissions or treatments. As the patient, responsible party, or guarantor of payment for patient, I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all Hospital charges, that to the extent permitted by applicable law, I shall pay all Hospital costs of collection including reasonable attorney's fees and/or collection agency fees.
4. **Property Release.** Release the Hospital from any responsibility for valuables, money, personal or other possessions which are not properly deposited by me with the Hospital depository and that in any event the Hospital's maximum liability shall be \$500.00.
5. **Acknowledgment of Receipt of Notice of Privacy Practices.** Acknowledge that I have received or decline the MedStar Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

For Georgetown University Hospital Use Only

Patient signature / acknowledgement of receipt of Notice of Privacy Practices not obtained because:

- Emergency patient
- Patient / Patient Representative declined to acknowledge
- Patient / Patient Representative unable / unwilling to acknowledge receipt

 GUH Representative

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions on the backside of this form and that I am authorized as the Patient or the Patient's Representative to sign this document and be bound by its terms.

 Signature of Patient or Patient Representative

 Date

 Printed Name of Patient Representative

 Relationship to Patient

OFFICE USE ONLY				
MRN	PHYSICIAN	FORM REVIEWED CARDS XEROXED	DATE KEYED	D/E INITIALS
		BY _____		



MedStar Georgetown University Hospital

Form A Adolescent Treatment Authorization

The policy of all physicians at the Georgetown University hospital Adolescent Medicine clinic is to maintain parental involvement in their adolescent's care. However, there may be instances when your adolescent will present for medical care without an accompanying parent or legal guardian. This visit could be for many reasons, including vaccination series completion, routine medical care and sick visits. At those times your daughter/son will receive the indicated and necessary medical treatment with the same care and consideration that is extended when you are present with your adolescent.

I consent to the examination and treatment of _____ (Print Student Name and DOB) by physicians and/or staff of MedStar Georgetown University Hospital – Kids Mobile Medical Clinic/ Ronald McDonald Care Mobile Program. It is understood that this treatment may be rendered in my absences if he/she should present for care without a parent or legal guardian. ***This consent shall be valid unless and until a written revocation is received by the KMMC from the parent or guardian or until the adolescent is able to grant their own consent for treatment.*** If you agree to the extent of our services please print and sign your name below.

I understand that my son/daughter will be seen for both Student Health Services AND Regular on-going health care services at the Kids Mobile Medical Clinic/ Ronald McDonald Care Mobile. This may include, but is not limited to, well adolescent care, sick visits, routine annual school/sports physicals, immunizations/shots, hearing and vision screening, tuberculosis screening. I further consent to the drawing of blood and any necessary laboratory testing necessary. I also understand that medical problems that are identified or arise during these services will be brought to my attention as necessary.

Parent/Legal Guardian (Signature) _____ Date _____

Parent/Legal Guardian (Print) _____ Telephone Number _____

Relationship to adolescent _____

Witness _____ Date _____
(Witness must be an individual over the age of 18 that has the capacity necessary to service as a witness. Witness may not be an employee of MGHU or KMMC)

Knowledge and Compassion
Focused on You



Guidelines for Adolescent Preventive Services

Parent/Guardian Questionnaire

Confidential

(Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
 Yes No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
 Yes No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
 Yes No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
 Yes No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
 If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
 Yes No Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seiures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sister(s)/ages _____ |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Guardian | <input type="checkbox"/> Alone |
| <input type="checkbox"/> Other adult relative | <input type="checkbox"/> Brother(s)/ages _____ | |

10. In the past year, have there been any changes in your family? (Check all that apply.)

- | | | | |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of job | <input type="checkbox"/> Births | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to a new neighborhood | <input type="checkbox"/> Serious illness | |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> A new school or college | <input type="checkbox"/> Deaths | |

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	<input type="checkbox"/>	Guns/weapons	<input type="checkbox"/>
Physical development	<input type="checkbox"/>	School grades/absences/dropout	<input type="checkbox"/>
Weight	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco	<input type="checkbox"/>
Change of appetite	<input type="checkbox"/>	Drug use	<input type="checkbox"/>
Sleep patterns	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>
Diet/nutrition	<input type="checkbox"/>	Dating/parties	<input type="checkbox"/>
Amount of physical activity	<input type="checkbox"/>	Sexual behavior	<input type="checkbox"/>
Emotional development	<input type="checkbox"/>	Unprotected sex	<input type="checkbox"/>
Relationships with parents and family	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Choice of friends	<input type="checkbox"/>	Sexual transmitted diseases (STDs)	<input type="checkbox"/>
Self image or self worth	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
Excessive moodiness or rebellion	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual)	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Work or job	<input type="checkbox"/>
Lying, stealing, or vandalism	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs	<input type="checkbox"/>		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? Yes No