Health Services Consent

HOMER CENTRAL SCHOOL DISTRICT

Student name: _____ DOB: _____ School & Grade: _____

Parent/ Guardian Information

Mother/Guardian: _____ Cell/Home: _____ Work: _____

Father/Guardian: _____ Cell/Home: _____ Work: _____

Parent/Guardian Address: _____

Health Insurance (Please circle and complete, if applicable):

Medical Insurance: Uninsured Medicaid Private Insurance

Policy Holder's name and date of birth for private insurance: _____

Private Medical insurance policy number _____ Group Number: _____

Preferred Pharmacy: _____

☐ **Please check here if you would like to be contacted by Guthrie Medical Group Patient Advocate for assistance with accessing health insurance benefits**

Student's Health Status

Child's pediatrician: _____ Phone: _____ Date of last physical exam: _____

List of allergies: medicines, foods, bee stings, etc. _____

List of medications your child is currently taking _____

Has your child been hospitalized in the past year? Y / N If yes, why? _____

Has your child had any surgeries in the past year? Y/ N if yes, describe _____

I authorize Homer Schools and Guthrie Medical Group Health Care providers to share student information as appropriate to ensure health care can be provided as needed to assist in the treatment and/ or continuity of care for my child. These records may include the following; immunization records, class schedules, parent contact, address, phone number, medical, behavioral and mental health conditions, health screenings, medications, health care plans, or attendance information. I authorize Guthrie Medical Group Health Care providers to contact my son/ daughter's primary care physician as part of school health services. I further grant approval for the health care provider to participate in student health care planning or attendance teams as needed. I hereby authorize the School Health Services provider to provide the services as indicated above. This consent will be in effect for one year form this date.

_____ _____

Parent/Guardian Signature **Date**

Please return the signed, completed form to your child's school. If you have questions or need assistance, Please contact the school nurse or principal.