# Homer Central School District

School Health Services Consent Form

Dear Parent/Guardian:

We are excited to share that Homer School District is continuing our partnership with Guthrie Medical Group, GMG, to provide health services to students. We know that students' health and success in school are absolutely connected. We have seen that by bringing services directly to students during the school day, we can proactively meet their health needs and support overall health, wellness and school attendance.

If you would like access to school health services for your child(ren), please complete the consent on the back of this letter and return to your child's school. GMG Health Services staff cannot provide medical services and/or treatment without written consent. Please note: NYS mandated physical exams and screenings can be provided however, as appropriate, without consent.

Examples of services provided include:

- Medical care and treatment, including diagnosis of acute and chronic illness and disease.
- Medically prescribed laboratory test such as strep test, and some medications, such as antibiotics.
- Annual health assessment.
- Referrals for service not provided through school health services
- Comprehensive physical examination including those for school, sports, working papers, etc.
  (Consent not required)

We look forward to partnering with Guthrie Medical Group and health and wellness for all!

Sincerely,

Thomas M. Turck
Superintendent of Schools

# 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.***