BORINQUEN MEDICAL CENTERS

GENERAL CONSENT FOR CLINICAL SCHOOL HEALTH SERVICES

STRICTLY CONFIDENTIAL – FOR HEALTHCARE USE ONLY

Please assist us with delivering the best care for your child by providing the following information. Print the following information for the student/patient:

Student Name:		Student ID:	
D.O.B. / /	Age:	Gender: M F	
Address:	City:	Zip Code:	
Telephone Number	Home:	Work:	
Number of members in household:	Parent Email:		

MEDICAL HISTORY

Check all that applies:	Asthma	Diabetes	Seizure	Allergies	No known Allergies
Other (please specify):					

LIST HOSPITALIZATIONS/SURGERIES:

Name of Primary Care Physician (if applicable):	Phone #:

If STUDENT has insurance coverage, please complete the following:

Medicaid #	Kidcare #	Private #	Policy #

Check the name of your child's health insurance plan:

Amerigroup	Children's Medical Services	Coventry	Humana	Molina
Preferred Medical	Prestige	Simply	Staywell	Sunshine
United Healthcare	Magellan	Other:		

The School Health Team MAY provide the following services, if needed or requested. Please check (v) the services that you would NOT like your child to receive:

Health Screening	Immunizations/Vaccinations	Behavioral Health Services
Physical Exams	Nutrition Evaluation and Consultation	Mental Health Services
Physical Exam (well child)	Physical Exam (sports physical)	Adolescent Health Services
Students will be referred to their Primary Care Physician where appropriate.		

General Consent for School Health Services and Treatment

By signing below, I hereby consent and authorize the **(**Borinquen Medical Centers of Miami-Dade**)**, the nurses, clinical, and mental health personnel of the school health team to conduct a clinical assessment as necessary and to provide school health services to the above named student, including first aid, medication administration, vaccines, mental health services, and/or any other school health service or treatment which in their judgment may be deemed necessary to address the above named student's medical condition, EXCEPT FOR only those specific School Health Services above that are checked.

I understand that the results of medical information obtained while my child receives treatment at the school health facility is confidential and will not be disclosed to anyone without my written permission or a court order as required by applicable federal and state laws. I understand Florida laws require the school healthcare team to provide the Department of Health with a report of those individuals diagnosed with communicable diseases. Therefore, I authorize the school healthcare team to report to the Department of Health whenever my child is diagnosed as having a communicable disease. I further understand that my child and/or I will be notified of any such diagnosis. Without written notification to change my preferences related to my child's treatment, I understand that this consent expires on the date that my child is no longer enrolled in the school.

I consent to the use and release of medical information as necessary for treatment, payment and healthcare operations of the school health team, including to the treating provider, state/local registries information, guarantor of accounts, or third party payors for which I have assigned benefits or which may otherwise reimburse for the provision of services, and if requested to my primary care physician or any other healthcare provider for the purposes of continuity of care.

I _____ am related to the child as _____
(print name) (Mother, Father, legal guardian)

I am legally authorized to sign this document _____ Date: _____
(Signature of parent/legal guardian)

Daytime phone: _____ Cell Phone: _____ Evening phone: _____