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Akron Children's Hospital

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

Clear Form | Print Form

Children's Hospital Medical Center of Akron ("Children's") and _____ School District ("School District") are partnering to offer School-Based Supplemental Health Services to School District students. The goal of this program is to help improve the health and well-being of students so they can be successful in school. The purpose of the school health services offered is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. Please review the School Based Health Center information sheet attached to this Consent for additional information about the services available. It is your responsibility to tell Children's about changes in insurance coverage and to notify the school nurse and Children's with all updates or changes to your child's health condition(s), immunization records, or medications. We are NOT trying to replace your regular source of healthcare. **School nursing and emergency services will still be provided as always whether you consent to participate in the program or not. Please make sure you complete each section. We cannot provide services to you/your child if any information is missing.**

Student / Family Information (Print all information in ink.)

Student's First & Last Name:	Student's Date of Birth: (month/day/year)	Sex Assigned at Birth: (Male/Female)	Preferred Pronouns: (He/She/They)

School:	Grade:	Relationship to Student:	Phone Number:	Preferred Language:

Parent/Guardian First & Last Name:	Street Address:

City:	State:	Zip Code:	Preferred E-Mail Address:

Health Provider Information

Date of student's last physical _____

☐ No physical in last 12 months

Doctor's Name: _____

Address/Phone: _____

Pharmacy Name: _____

Location: _____

Insurance Information

Insurance Name: _____

Insurance Address: _____

Subscriber Name: ID #/ _____ Subscriber DOB: _____

MMIS: _____ Group #: _____

☐ NONE, please connect me to Children's financial counselor.

All services provided are billed to insurance. If you do not have insurance, Children's will connect you to financial assistance. No child is denied services for inability to pay.

I consent to allow the Children's health care providers who are providing services at School District to perform the following services / treatment and vaccines for the above-referenced student:

Services

Below, place an X next to each service you want your child to receive.

☐	Care and treatment for any injury/Illness
☐	Physical examinations / well-child (i.e. sports, work, school). **Note:** Well-child care includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate.
☐	Vaccine(s) Only

Vaccinations

☐ **YES**, I wish to have **ALL** vaccines listed below available for my child (do not mark any further boxes in this section).
☐ **NO**, I only wish to have the vaccines marked below available for my child (please mark all boxes of vaccines that you would like available for your child below).

Required Vaccines* for school attendance in Ohio.		**Recommended Vaccines*** but not required to attend school in Ohio.	
☐	DTaP / Tdap / Td	☐	Influenza (flu)
☐	Meningococcal / Men B	☐	HPV
☐	MMR	☐	Hepatitis A
☐	Varicella	☐	Pneumococcal
☐	Polio	☐	Hib
☐	Hepatitis B	☐	COVID-19

*Age appropriate, following the American Academy of Pediatrics vaccination schedule.

FM00152
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Student Health History

Select and describe if your child has or has had any of the following:

Medications ☐ YES (list below) ☐ NO

1) 2) 3)

Allergies ☐ YES (explain below) ☐ NO

1) 2) 3)

Surgeries (when?) ☐ YES (explain below) ☐ NO

1) 2) 3)

Other medical problems health concerns ☐ YES (explain below) ☐ NO

1) 2) 3)

Please explain any other medical information:

Consent For Medical Treatment

Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the student. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

I and/or my parents(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or designees, do all things that may be needed to diagnose, treat and care for the needs of the above-referenced student. Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care. I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, internal education purposes, legal purposes and quality improvement purposes. I understand and agree that Children's may at its discretion provide certain services to me by remote means called "telehealth." Children's may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedure(s). I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or judgments. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PATIENT RIGHTS/PRIVACY INFORMATION: I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

Patient Rights and Responsibilities	Advance Directive Information (Patients 18 years and older)
Complaint/Grievance Procedure	Free Hospital Care Information
Health Information Exchange Brochure	"An Important Message from Medicare" (Medicare patients)
HIPAA Notice of Privacy Practices	"An Important Message from Tricare" (Tricare patients)

AUTHORIZATION TO COMMUNICATE: I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text messaging, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback, and communicating/discussing financial responsibilities. By signing this form, I am granting permission to Children's to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID:
I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

Privacy Practices

Children's Notice of Privacy Practices: Children's Notice of Privacy Practices is available upon request at any School District building where services are provided. You can also view the Notice of Privacy Practices online at https://www.akronchildrens.org/pages/Privacy-Policy.html. Children's Notice of Privacy Practices describes how Children's may use and disclose you/your child's health information and how you can access you/your child's health information. By signing this Consent, you acknowledge and agree that information regarding the services provided to you/your child may be shared with School District nurses, counselors, and social workers involved in you/your child's care and with you/your child's health care providers for treatment purposes. Except as provided above and in Children's Notice of Privacy Practices, Children's will not disclose you/your child's health information without your written authorization.

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I have read this consent form or have had it read to me, and it has been explained to my satisfaction. This consent will remain valid while the student is enrolled in the School District named unless revoked in writing to Children's by the student's parent/guardian or the student if the student is over 18 years of age.

By signing below, I acknowledge that I understand and accept the terms of this consent and confirm that I have legal ability to consent for the treatment.

OPTION 1 In-Person Consent for Treatment

Printed Name of Patient	Signature of Patient (If 18 years or older)	Date	Time
Printed Name of Parent/Guardian and Relationship	Signature of Parent/Guardian (If patient is less than 18 years)	Date	Time
Printed Name of Witness to Consent	Signature of Witness to Consent	Date	Time

OPTION 2 Telephone Consent for Treatment (REQUIRES 2 Witnesses)

Name of Person Contacted: _____ Relationship to Patient: _____

Contact Date / Time: _____ Consent Granted? ☐ Yes ☐ No

Contact Phone Number: _____

Printed Name of Witness #1 to Telephone Consent	Signature of Witness #1 to Telephone Consent	Date	Time
Printed Name of Witness #2 to Telephone Consent (If not provider)	Signature of Witness #2 to Telephone Consent	Date	Time