MERCYHEALTH

## Parental Consent and Registration for Services
## Mercy Health – Little Miami School Health Center

☐ **Yes**, I give permission for my child to receive services provided by Mercy Health – Little Miami School Health Center, a school-based health center (SBHC), and as determined by the Center's medical staff.

- The consent will remain in effect until my child is no longer enrolled in Little Miami school district or until I revoke consent in writing. It is my responsibility to notify the school about changes in legal guardianship.
- I understand that the SBHC will notify me about seeing/treating my child. This will be done by telephone or in writing.
- I authorize the SBHC and its staff to communicate with my child's doctor/clinic about care/services.
- I authorize the SBHC to bill my health insurance provider for services rendered.

**Child/Patient's Name** _____ **Date of Birth** _____ **SS #** _____
Last First Middle

**School** _____ **Grade** _____

**Child/Patient's Sex**_____ **Race/Ethnicity**_____

Parent Phone # _____ Cell # _____ Work # _____

Home Address _____City _____ State _____ Zip Code _____

**Parent/Guardian's Name** _____**Parent Date of Birth** _____ **Parent SS #** _____
Last First Middle

**Child/Patient Allergies (including medications)** _____

Emergency Contact (other than listed parent) _____ Relation_____ Phone #_____

Name of Primary Doctor or Clinic _____ Phone # _____

Preferred Pharmacy _____ Phone # _____

**Would you like your child's annual well child exam completed at the SBHC?** YES NO

**Name of Health Insurance or HMO** _____

**If parent/guardian's policy, insured parent's name and date of birth**_____

**Medical Card or Insurance Member ID** _____ (Please provide a copy of insurance card)

**Confidentiality:** The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. However, I understand that at times it may be necessary for team members of the SBHC to confer amongst themselves and the school health assistant about health issues related to my child. I understand that, as a courtesy, a record of any service or care to my child at the SBHC will be forwarded to his/her family doctor or clinic. I understand that data not specific to an individual child may be used to evaluate the program.

**Signature of Parent or Legal Guardian** _____

**Date** _____