Student's Name_____

School Based Health Consent for Services
The Wellness Center @ Shawnee

Please read carefully: In order for us to see your child in ***The Wellness Center@ Shawnee***, all pages of this form must be completed by the child's parent or legal guardian, **signed and dated** in ink in the appropriate places. Students should return the completed form to their teacher. Consent is for the 2015-16 school year and may be withdrawn at any time.

Child's School:_____

_____ _____ _____
Student's Last Name First Name/ Middle Initial Date of Birth

Social Security Number: _____ Gender: ___Male ___Female

Race: ___American Indian or Alaska Native ___Asian ___Black or African American
___ Native Hawaiian or Other Pacific Islander ___White

Ethnicity: Are you Hispanic or Latino? ___Yes ___No
Primary Language: _____ Religion Preference: (optional) _____

Address: _____
City _____ State _____ Zip Code _____

Physical Address (If Mailing Address is a P.O. Box):
_____

Home / Cell Phone Number: _____

In Case of Emergency Please Contact:
Name of Mother/ Legal Guardian_____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

Name of Father/ Legal Guardian: _____

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number e-mail address

If Immediate Family is Not Available, Please Contact:

Name and Relationship to Child: _____

_____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number

Student's Name_____

Immunization Status:

Is your child up to date on immunizations? ___Yes ___No

Where is the child's immunization record on file: _____

___Yes, I give permission for school nurse to request a copy of immunization record

Other:

Do you have concerns about your child's health? ___Yes ___No

Is your child exposed to second hand smoke? ___Yes ___No

Does your child smoke and/or use tobacco products? ___Yes ___No

Does your child drink alcohol? ___Yes ___No

Cross out any Over the Counter medications below you DO NOT want your child to receive

___ Acetaminophen (Generic name for Tylenol)
____ Topical mouth/tool pain reliever (Orajel, Orasol etc.)
____ Lotion
____Zofran for nausea
____ Triple antibiotic ointment (Neosporin, Bacitracin etc.)
____ Tussin DM
____ Solarcaine spray for burns and scrapes
____ Immodium for diarrhea
____ Claritin for allergies
____ Eye Wash, Irrigating Solution
____ Topical Antiseptic (Benzalkonium Chloride)
____ Ibuprofen (Generic name for Advil)
____ Lip Ointment (Blistex, Chapstick etc.)
____ Sore throat spray
____ Refresh Plus Eye Drops/ Refresh
____Cough Drops
____ Diphenhydramine (Generic for Benadryl)
____ Hydrocortisone 1% Cream
___ Hydrogen Peroxide (for wound cleansing)
____ Tums for indigestion
____ Simethicone for gas
____ Finger stick blood glucose testing
____ Sting Relief Swabs

INCOME ***Note: Shawnee Christian Healthcare Center is dedicated to providing health care to the community. We rely on grant funds to support our school based health programs. By providing the income information requested, this will help us report about the population we serve and is important when applying for grants. THANK YOU FOR YOUR HELP!***

Family Size	Annual Income (please circle one)			
1	Below $11,770	$11,771-17,655	$17,656-23,540	Above $23,540
2	Below $15,930	$15,931-23,895	$23,896-31,860	Above $31,860
3	Below $20.090	$20,091-30,135	$30,136-40,180	Above $40,180
4	Below $24,250	$24,251-36,375	$36,376-48,500	Above $48,500
5	Below $28,410	$28,411-42,615	$42,616-56,820	Above $56,820
6	Below $32,570	$32,571-48,855	$48,856-65-140	Above $65,140

Student's Name_____

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

Date _____ Signature of the Parent/Legal Guardian _____

Best **phone number** to reach you _____ **Email** to link you to Patient Portal for child's health record _____

Date _____ Signature of Witness _____

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

Date	Phone Number	Witness Name	Address
Date	Phone Number	Witness Name	Address

61472215.1

Student's Name_____

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The Wellness Center @ Shawnee

Know Your Patient Rights

Civil Rights

1. Patients have the right to considerate and respectful treatment in an environment free of harm.
2. Patients seeking services shall not be denied, suspended, or terminated from services or have services reduced for exercising any of their rights.

Discrimination

1. Patients have the right to receive services regardless of age, sex, race, creed, color, religion, national origin, ancestry, marital or parental status, physical or mental disability, sexual orientation, gender identity or expression, veteran status, political affiliation or beliefs, or criminal record.
2. Patients may receive services without regard to one's ability to pay; if you are unable to pay the full fee for services, a sliding fee scale is available to you. You may examine and receive an explanation of your bill of services.
3. No recipient of services is presumed legally incompetent except as determined by a court.
4. Patients have the right to present any complaint or grievance on matters pertaining to services received, or any perceived or actual violation of rights.

Treatment

1. A recipient of services shall be provided with adequate and humane care and in the lease restrictive environment, pursuant to an individualized service plan. When appropriate, a recipient's nearest kin or guardian shall be involved in the treatment/service plan.
2. Patients have the right to know of the variety of services that may be available and to participate in the planning of treatment.
3. Patients may refuse treatment at any time, and patients have the right to be informed of the consequences resulting from the refusal of treatment.
4. Seclusion will not be used as a means of intervention for any recipient services.

Confidentiality

1. Patients will receive confidential treatment; all clinical records and client information are protected by law, regulations and center policies. For the purposes of funding, certifications, licensure, audit, research or other legitimate purpose, your clinical record may be used by the person conducting the review to the extent that is necessary to accomplish the purpose of the review.
2. Patient information released to or requested from other sources requires your written consent. Patient records can be subpoenaed by court order and does not require your signature for release of information.
3. Patients have the right to review, and obtain a copy of your clinical record in accordance with SCHC's policy.

SCHC SHAWNEE CHRISTIAN HEALTHCARE CENTER
"Serving God - Serving People" Matthew 25:40