2022-2023 CONSENT FOR SCHOOL HEALTH SERVICES THROUGH THE FOUR RIVERS FOUNDATION

Student Information

Last Name: ______________ First Name: _________________ MI: _________________

Date of Birth: ____________ Grade: _______ Homeroom: _________________ Male/Female: ______

Address: ____ City: ____________ Zip: ______________

Mother/Guardian: _________________ Home/Cell #: ________________ Work #: _________________

Father/Guardian: _________________ Home/Cell #: ________________ Work #: _________________

Social Security Number: __________________

Emergency Information

Emergency Contact: ____________________ Home/Cell #: ________________ Work #: _____________

Emergency Contact: ____________________ Home/Cell #: ________________ Work #: _____________

Child's Primary Care Provider: ____________________

Student Medical Information

List all significant medical history:

____

____

List any allergies and the type of reaction:

____

____

Does your child take any medications and if so, what?

____

____

Does your child require emergency meds? (epi pen, seizure meds, insulin, etc)

____

Student Medical Insurance

Does your child have a Kentucky Medical Card or K-chip? Yes/No _________________________

Does your child have any other medical insurance? Yes/No _________________________

Insurance name and number on card:________________________________

Consent for Services

To receive services a guardian needs to be available by telephone or in person if needed

Consent for evaluation by Dr. Alex Wright if needed? Y/N

Consent for treatment by Dr. Wright if needed? Y/N

Consent for physical examinations for school and sports? Y/N

Consent for care for chronic conditions when deemed appropriate or needed by Dr. Wright (asthma, ADD, etc)? Y/N

Consent for Health Services and Assignment of Benefits

As the legal guardian/parent, I consent to the above consents for the treatment of my child. In the event of an emergency that occurs while Dr. Alex Wright is on premises, he will act under the ethical and medical obligations to provide medical care to the best of his extent and/or assist in triaging the student to emergency medical services. In the event, Dr. Wright is not available, the usual protocol for school nurses will be enacted. I consent to the record release if needed to the child's primary care provider or other medical personnel directly involved with the student care. I understand that all patient sensitive information will be handled according to federal HIPPA guidelines which exist to protect the privacy of all patients. I understand that these services are to be used to supplement those students that have limited access to a health care provider appointment and not to be in place of the student's primary care provider. I acknowledge as well that in the future, based on complexity and time of care that insurance may be billed but this will not result in any cost to the student or parent. This service is not currently available and if it becomes available, as it will allow for expansion of care for many students, further details will be given in advance. Furthermore, I agree to be available at the contact information provided if needed. I understand that this program is to promote the health of my child and to help ensure his/her ability to recover or be managed appropriately based on the presentation of the illness or injury. I agree that if my child worsens or the condition changes, that I am responsible to have them reevaluated and treated appropriately at that time.

Signature of Parent/Guardian: ____________________________________ Date: ________________

This form must be signed to receive the above services. Consent expires one year after the date of the signature or at the start of the next calendar school year and will need to be completed at the start of each school year.