School-Based Health Centers
Consent for Health Services

School-Based Health Centers located in Seattle Public Schools must have a signed consent from a parent or legal guardian before providing services to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. Youth may independently access reproductive health care at any age; they may independently receive drug and alcohol services and mental health counseling from age thirteen. If necessary, the Centers will inform youth of options for outside care and will assist the youth in discussing these issues with parents/guardians. If the youth is enrolled in school but is not enrolled in a School-Based Health Center, he/she can continue to receive school nurse services.

I hereby request and authorize that:

Print Youth's Name: _____ _____
First Name Middle Initial Last Name Birthdate

receive any and all health care services available from and deemed necessary by the staff of the SBHC. These services may include, but are not limited to, such procedures as well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and X-rays. Consent is also given for referral of care and if needed, emergency transportation, to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Center and its staff. This authorization does not allow services to be rendered without the youth's consent, unless she/he is unable to consent.

When consent is provided for care, all information is kept confidential except in the following circumstances:

1. The client gives permission through a signed release of information.
2. If he/she indicates risk of imminent harm to self or others.
3. He/she has a life threatening health problem and is under 18 years old.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.
6. Certain non-protected information such as yearly physicals and immunizations and general information regarding the healthcare you receive at the School-Based Clinic may be included in your medical record and/or shared with your primary care provider. No confidential information will be shared without the students consent.

I understand the youth's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), and alcohol and drug or mental health counseling.

The School-Based Health Center encourages each youth to involve his/her parents or guardians in health care decisions whenever possible.

Consent for services is authorized for the length of time the youth is enrolled in a school with a SBHC. I may choose to withdraw the consent at any time by writing to the Center that serves the youth.

Youth Signature: _____Date: _____

Parent/Guardian Signature: _____**Date:** _____

Name/Relationship of Legally Responsible Guardian (Print):_____

Parent/Guardian Address:_____

Parent/Guardian Email Address:_____

Telephone: (_____)_____ Work Telephone: (_____)_____

School-Based Health Center Registration Form

*Please help us serve you better and comply with our reporting requirements by providing the following **confidential** information.*

Student's Name: _____
Last First Middle Preferred

☐ Female ☐ Male ☐ Trans*/Gender Non-Conforming

Student's School ID: _____ Birth Date: _____ Social Security #:_____ *(optional)*

Student's Address: _____ Student's Cell:_____
Street City State Zip

Contact Name:_____ Phone: _____ Relationship to Student: _____

Is the student Spanish/Hispanic/Latino? ☐ Yes ☐ No

Which of the following best describes the student's race? (Check One)

☐ African American/African Native ☐ American Indian/Alaskan Native ☐ Asian
☐ Pacific Islander ☐ White ☐ Multi-Racial

Supplemental Information
Who referred the student to the clinic?: _____ Student's Grade?: _____

Does the student have a doctor? ☐Yes ☐No

If yes, please provide name and phone number_____

Does the student have permanent place to live? ☐Yes ☐No

What is the student's preferred language: _____ Family Language: _____

Is the student eligible for the Free or Reduced Lunch Program? ☐ Yes ☐ No ☐ Don't Know

List activities in which the student is involved: _____

Medical / Mental Health History
Does the student have any medical problems or mental health concerns? _____

Does the student need medications on a regular basis? _____ What?_____

Has the student ever had any surgery, serious illness, or injury? _____

Does the student have allergies to any medications? _____

Has anyone in the student's family had the following (Check all that apply)

☐ asthma	☐ diabetes	☐ heart problems/stroke	☐ mental health problems	☐ alcohol or chemical use
☐ cancer	☐ seizures	☐ high blood pressure	☐ high cholesterol	☐ died before age 50

Insurance Information
You can support the Health Center by providing your insurance or Medicaid information. ***Completion of the information below is required so that we can bill your insurance company, if applicable. No one will be denied services due to inability to provide this information.***

Is the student insured? ☐ Yes ☐ No Insurance ☐ Don't Know

Plan Type: ☐ Medicaid/Healthy Options ☐ Basic Health Plan ☐ Private/Commercial ☐ Group Health

Insurance Company:_____ Plan Name: _____

Policy Holder's Name: _____ Policy Holder's Social Security #:_____ *(optional)*

Group Number or Medicaid Number: _____

Consent to Release Information to Insurance Carrier: I certify the information supplied above is accurate. I authorize release of medical and related information to my health insurance company or other third party payor for the purpose of obtaining payment for services rendered. Policies are in place to assure privacy is maintained related to confidential services.

Signature: _____ **Date:** _____ **Relationship to Student:** _____

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Please complete both sides