Revised: 9/2/2021

North Country HealthCare
Parental/Patient Consent Form

North Country HealthCare School-Based Health Services Program-Mobile Unit
2920 N. 4th Street, Flagstaff, Arizona 86004

STUDENT INFORMATION

Student's School/Grade:_____

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female

Student's Address: _____

_____

_____ _____ _____
City State Zip Code

Student's regular doctor?

Name: _____

Telephone: _____

Address: _____

***NCHC will share health information with your child's primary care physician.**

PARENT/GUARDIAN INFORMATION

For Students younger than 18 years old:
Parent/Legal Guardian:

Name: _____

Date of Birth: _____/_____/_____

Relationship to student: _____

Home Tel: _____Work Tel: _____

Cell: _____

Ok to leave a detailed message at these #'s ? ❑ Yes ❑ No

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child or you, if 18 years or older, have Private or AHCCCS insurance? ❑ Yes ❑ No **If "Yes" complete below:**

Insurance Name: _____

Subscriber/Policy Holder : _____

Group Number: _____

Subscriber/Policy Number : _____

If your child does not have health insurance coverage, would you like to be contacted by a representative of North Country HealthCare regarding a Sliding Fee Scale option?
❑ No ❑ Yes

PARENTAL/PATIENT CONSENT FOR SCHOOL-BASED HEALTH CENTER- MOBILE UNIT SERVICES

I consent for my child or myself, if 18 years or older, to receive healthcare services provided by the state-licensed health professionals of North Country HealthCare School-Based Health Services Program-Mobile Unit. School-Based Health Program services may include, but are not limited to: ***PLEASE CHECK EACH BOX TO ACKNOWLEGE THE SERVICE**

- ☐ Comprehensive physical examination (complete medical examination).
- ☐ Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
- ☐ Medical care and treatment, including diagnosis of acute and chronic illness and disease, dispensing, and prescribing of medications and immunizations.
- ☐ Tests for respiratory infection such as for COVID19, RSV, and influenza.
- ☐ Dental examinations including diagnosis and sealants, fluoride application where available.
- ☐ Referrals for service not provided at the school-based health center.
- ☐ Release of my child's health information from FUSD to North Country HealthCare.

I have read and understand the services listed above and my signature provides consent for my child to receive services provided by the School-Based Health Program. An additional signature will be required on the back of this form for opt-in services.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

NCHC Office Use Only
Parent/Guardian Consent Obtained Verbally X_____ **Date** _____

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

North Country HealthCare
School Parental Consent Form

OPT-IN SCHOOL BASED HEALTH CENTER SERVICES- MOBILE UNIT SERVICES

I consent for my child to receive the below indicated opt- in health care services provided by North Country HealthCare School-Based Health Center-Mobile Unit. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

_____ Counseling and referral on reproductive health issues (age appropriate)

_____ Mental and/or substance abuse counseling

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

SCHOOL BASED HEALTH CENTER SERVICES
NORTH COUNTRY HEALTHCARE
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be shared between North Country HealthCare and FUSD (FLAGSTAFF UNIFIED SCHOOL DISTRICT), either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to North Country HealthCare. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the North Country HealthCare School-Based Health Services Program-Mobile Unit to release specific medical information of the student named on the reverse page to FUSD (FLAGSTAFF UNIFIED SCHOOL DISTRICT)

I consent to the release from North Country HealthCare to Flagstaff Unified School District of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law.

Information Required by Law:
- Immunizations
- Vision and hearing screening results

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment
- Conditions which limit a student's daily activity
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Health insurance coverage

My consent on page 1 of this form also authorizes North Country HealthCare to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:

From: _____ Date that form is signed on opposite page
To: _____ Date that student is no longer enrolled in the SBHC

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT