

Health Care Consent Form

A student must have a consent form signed before being treated at a Cedar Rapids Community School District Metro Care Connection health center. Please complete the following information, sign the form where indicated and return it to the school health center. Thank you**

General Information

Student Name _____ School _____ Grade _____
 Student aliases or other names _____ Date of Birth _____ Sex _____
 Ethnicity _____ Student race _____ Email address _____
 Language spoken _____ Written language _____ Preferred Language _____
 Address _____ Home Phone _____
 City _____ St. _____ Zip _____ Cell Phone _____
 Parent/Guardian Name _____ Emergency Phone _____

Student Health History

Does your child have any allergies to **medications**? ____ Yes ____ No

Please list **all of** your child's allergies: _____

Please list any health conditions your child has (such as asthma, diabetes, seizures, ADHD, depression):

Please list any medications/treatments your child is currently receiving: _____

Please list any surgeries your child has had: _____

Consent to Receive Services

I give my consent for my child to receive health services from the Metro Care Connection health center including over the counter medications. If I have requested that my child receive a routine or sports physical, I understand that an age-appropriate complete full-body exam will be offered as part of our comprehensive services. I understand that all information about my child is confidential and will be treated in accordance with acceptable medical practice and the federal and state laws regarding privacy.**

X
Date

Parent/Guardian Signature

While I consent to having services provided to my child, I **DO NOT** want him/her to receive the services noted:

Physician

Do you have a physician? ____ Yes ____ No If yes, what is the physician's name _____

I authorize Metro Care Connection Health Center staff to contact my child's physician/health care provider to share information concerning my child's health by fax, phone, etc.

X
Date

Parent/Guardian Signature

7/15

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Insurance Info

Insurance Status

My child has (please check all that apply): no health insurance Social Security Number _____
 HAWK-I Title 19 (please provide Title 19 policy number _____)
 private insurance: Are "well visits" covered? Yes No **Name of insurance company** _____

Please bring a copy of the student's insurance card to the child's appointment.

Release of Information and Acknowledgement of Privacy

*Iowa Medicaid allows for Local Education Agencies (CRCS's Metro Care Connection) to request reimbursement for Primary and Preventive services provided by Metro Care Connection. I **authorize** MCC staff to disclose personally identifiable information belonging to my child to the Iowa Department of Human Services and its contractors, ("Medicaid") for purposes of determining my child's eligibility for Medicaid, and if my child is determined to be eligible for Medicaid, for purposes of billing Medicaid for Medicaid-covered health services provided to my child. Should my child have other insurance in addition to Medicaid, I understand that Medicaid may forward claims to the other insurance for processing. This process is in compliance with all federal regulations and would not impact the existing benefits or impact access to any services. I understand that a photocopy or other reproduction of this signed and completed form shall have the same force and effect as the original, unless otherwise prohibited by law.

_____ **Date**

Parent/Guardian Signature

Electronic Health Record Notice

- I understand that my child's Metro Care Connection health visits will be a part of the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System. Because my child has a medical record within the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System I understand that my child's record may be viewed by MercyCare Service Corporation health care employees and in some situations could be viewed by other healthcare providers outside of Mercy through the EPIC Care Everywhere connection, and I consent to any disclosure consistent with this paragraph.

_____ **Date**

Parent/Guardian Signature

Privacy Notices

- I acknowledge that I have had opportunity to read/receive Metro Care Connection's FERPA Notice of Right's and HIPAA Notice of Privacy Practices. A copy of the full disclosures can be obtained in one of our MCC clinics or accessed on the MCC website <http://mcc.cr.k12.ia.us>.

_____ **Date**

Parent/Guardian Signature

Transportation

I give my consent for my child to be transported for health care services if I am unavailable. (Regulation 901.7)

_____ **Date**

Parent/Guardian Signature

** Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), 20 USC § 1232g, 34 CFR §99.31, the school corporation, prior to disclosing personally identifiable information from a student's records to the Iowa Medicaid agency, must obtain written consent from the student's parents specifying records to be released, the reasons for such release, and to whom, and with a copy of the records to be released to the student's parents and the student if desired by the parents. This signed authorization is valid for a period of one (1) year from the date signed. This form must be maintained and made available for audit purposes.*

*** Iowa Code Sections 139A.35 and 141A.7 provide that a minor may consent for diagnosis of pregnancy/sexually transmitted disease (STD) testing and the treatment of any STD and that the consent of a parent or guardian is not necessary for these services.*