MAUSD School-Based Health Center Permission Form

To enroll your student in the School-Based Health Center, complete this form (and all other forms in this packet) and **return to the Mt Abe Nurses Office. This form is valid while your student is attending high school. All information on this form is confidential and will be securely stored at the Nurses Office.**

STUDENT NAME:	
DATE OF BIRTH:	**GENDER:**

Name of Parent/Guardian #1:	
Mailing Address:	
Email:	
Primary phone:	**Ok to leave message: Y/N?**
Secondary phone:	**Ok to leave message: Y/N?**
Preferred mode of contact [circle or check ONE]: Primary phone ___ Secondary Phone___ Email ___	

Name of Parent/Guardian #2:	
Mailing Address:	
Email:	
Primary phone:	**Ok to leave message: Y/N?**
Secondary phone:	**Ok to leave message: Y/N?**
Preferred mode of contact [circle or check ONE]: Primary phone ___ Secondary Phone___ Email ___	

Custody information:	
Emergency Contact Name:	**Telephone number:**

Medical Information: Please indicate yes or no and provide as much detail as possible. Attach extra information to the end of this form if necessary.

Does your student have:	Yes/ No	Further information
Allergies		If yes, please list/ describe:
Asthma		
Seizure disorder		
Diabetes		
Other medical concerns		If yes, please list/ describe:
Medications		If yes, please list/ describe:

Name of student's primary care provider:	Date of last physical:
Name of health insurance provider: PLEASE ATTACH COPY OF STUDENT'S INSURANCE CARD	

Financial Assistance: Financial Assistance is available. Please contact the Mountain Health Center at 802-453-5028.

School Based Health Center Enrollment: Parent/guardian/student age 18 or older must submit the following before participating in the School-Based Health Center:

- General Consent for Treatment Form
- Joint Notice of Privacy Practices Form
- Copy of insurance card

I understand that I am providing this consent for the purposes of obtaining professional health care services for my student and to assign any payments for these services to which I might be entitled to the "Service Organizations" (the health care providers staffing the clinic) involved in the School-Based Health Center.

Student's Primary Care Provider will be contacted when they are seen at the School-Based Health Center.

Acknowledgment of Release of Information: The School-Based Health Center works with a team of Service Organizations from local health care and social agencies to assist your students. To allow the team to work together effectively, we ask parents to authorize School Based Health Center staff, the individual Service Organizations and their supervisors to share information only when necessary.

PLEASE INITIAL BELOW: I authorize the School-Based Health Center staff, appropriate School District personnel, and the individual Service Organizations to discuss appropriate information with the following healthcare providers pertaining to my student, and only when needed:

Initial here:_____ MAUSD school-based guidance and mental health counselors, school health personnel, and assistant principal/principal.

Initial here:_____ My student's private mental health counselor/ Name of counselor:_____

(By not initialing one of these, I understand I am limiting the services available to my student)

PLEASE INITIAL IF APPLICABLE:

Initial here: _____ I authorize the School-Based Health Center and Service Organizations to communicate with my student's primary care provider.

READ AND SIGN BELOW:

I understand that I may revoke this authorization at any time (except to the extent that a Service Organization has already taken action based upon my prior consent) if I make a written statement revoking the authorization and deliver it to:

Health Office, Mount Abe Union School District, 220 Airport Drive, Bristol, Vermont 05443.

I, _____ (please print name of Parent/Guardian/Student age 18 or older) have read the above material and understand its meaning. My signature below is an acknowledgement that I have reviewed this form, understand the information and consent to all of the actions described. My signature also attests to the accuracy of the information provided on all pages of this form.

Parent/Guardian Signature: _____ Date: _____

Signature of Student age 18 or older: _____ Date: _____