METRO CARE CONNECTION
Cedar Rapids Community School District
School-Based Health Centers & Services

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_____

Date of Birth_____ Race/Ethnicity_____

Address_____ Home Phone _____Cell_____

Parent/Guardian Name_____ Email address_____

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/Insurance

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

My child has (please check all that apply):

___ no health insurance Social Security Number _____

___ Title 19 (please provide Title 19 policy number_____)

___ Hawk-I insurance

___ private insurance: Are "well visits" covered? __ Yes __ No **Name of insurance company**_____

Release of Information

*Iowa Medicaid allows for Local Education Agencies (CRCSD'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.

X **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)

X **Date**

Parent/Guardian Signature

1/08

***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.*