This is the consent form for the **Rales School Based Health Center (SBHC)** through a partnership with Johns Hopkins Children's Center!

Please review the information in the packet and decide if you want to enroll. Even if you want to say no, please return this form to the health center, the front office, or your child's teacher. Thank you!

STUDENT NAME (***PLEASE PRINT)*** GRADE LEVEL for 2017-2018

Please check **ONE** box (YES or NO) below regarding your family's participation in the School Based Health Center:

[ ] **YES, I have read the attached information and I DO want to enroll my child in the KIPP SBHC.** (Please sign and date the attached form)

[ ] **NO, I have read the attached information and DO NOT want to enroll my child in the KIPP SBHC.**

The Rales Center us working to provide the best services for KIPP. We may contact you in the future to learn more about your decision to enroll or not.

Rales School-Based Health Center at KIPP Baltimore
Parental Consent Form

Student Information	Parent/Guardian Information
Student's Last Name: _____ **Student's First Name:** _____ **Date of Birth:** _____/_____/_____ **Student's Social Security #:** _____ **Sex: [ ] Male [ ] Female Grade:** _____ **Race (check all that apply):** ☐ Black/African American ☐ White/Caucasian ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other: _____ **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic/Latino **Student's Address:** _____ _____ _____ _____ City State _____ Zip Code **Student's Primary Provider (Doctor or Clinic):** Name: _____ Telephone: _____ Address: _____ _____	**Parent/Guardian:** **Last Name** _____ **First Name** _____ **Date of Birth:** _____ **Relationship to student:** [ ] Parent [ ] Grandparent [ ] Aunt/Uncle [ ] Guardian [ ] Other: _____ **Home phone:** _____ **Work phone**:_____ **Cell Phone:** _____ **Other:** _____ **Parent/Guardian:** **Last Name** _____ **First Name** _____ **Relationship to student:** [ ] Parent [ ] Grandparent [ ] Aunt/Uncle [ ] Guardian [ ] Other: _____ **Home phone:** _____ **Work phone:**_____ **Cell Phone:** _____ **Other:** _____ **Additional Emergency Contact:** **Name:** _____ **Relationship to student:** _____ **Home phone:** _____ **Work phone:**_____ **Cell Phone:** _____ **Other:** _____ *It is very important that we are able to get in touch with you about your child's care. Please provide as many phone numbers as possible.*
Health Insurance Information	
Does the student have Medical Assistance insurance? [ ] No [ ] Yes Medical Assistance #: _____ **Does the student receive services through a MCO/HMO?** [ ] No [ ] Yes (please check the appropriate box below) **If yes, which plan?** [ ] Amerigroup [ ] Jai [ ] Kaiser Permanente	**Does the student have private or other health insurance?** [ ] No [ ] Yes Insurance company: _____ Name of person listed on insurance card: _____ Member ID number: _____ **If the student does not have health insurance, please provide the following information.** We will use it to

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Parental Consent Form

[ ] Maryland Physicians Care [ ] MedStar Family Choice [ ] Priority Partners [ ] Riverside Health [ ] UnitedHealthcare	determine insurance eligibility or sliding fee scale. Income: Weekly/Biweekly/Monthly/Annual (circle one) _____ # of family members: _____

Student Health History

Please answer these questions about your child's health.

Allergies: [ ] No [ ] Yes If yes, please describe: _____

Chronic conditions (examples - asthma, diabetes, emotional/behavioral problems): [ ] No [ ] Yes

If yes, please describe: _____

Medications: [ ] No [ ] Yes If yes, please list: _____

Other problems/concerns: [ ] No [ ] Yes If yes, please describe: _____

Parental Consent for School-Based Health Center Services

I grant permission for my child _____to enroll in the Rales School-Based Health Center at KIPP Baltimore. I consent to my child receiving school-based health center services that can include physical examinations, treatment for acute and chronic health problems, health education, mental health counseling, and limited diagnostic tests. I understand that if I cannot attend a visit, my child may be seen alone. I understand that school-based health center staff will try to contact me before unscheduled visits. For scheduled and unscheduled visits, I will get a written summary and staff will tell me about the visit, if I can be reached.

I understand that Maryland law allows a minor to give consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, and treatment or advice about birth control. A minor 16 years or older may consent to mental health services. Under these circumstances, only information necessary for billing purposes or as required by Maryland law will be released outside the health center.

I give consent for the submissions of all claims from the school-based health center, if applicable, to my private insurer, managed care organization (MCO) or health maintenance organization (HMO) and authorize direct payment to JHU for any benefits due. I understand that if my child is registered with a MCO through Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school-based health center. A summary of the visit will be sent to the primary care provider/private insurer/MCO/HMO.

Parent/Legal Guardian Name (Print): _____ Relationship to Child: _____

Parent/Legal Guardian Signature: _____ Date: _____