Blackfeet Tribal Health Services (BTHS)

School-based Clinic

213 2nd Street SW or PO Box 1289
Browning, MT 59417
Tel No: 406 – 338 – 7912
Fax No: 406 – 338 – 2373
Fax No: 1-855-259-1732

Consent To Treat

I authorize BTHS healthcare staff to render medical treatment for:

Name of Child: _____

Date of birth: _____

I am the legal guardian/parent (pls circle one) of this child

BTHS healthcare staff are authorized to:

- ✓ Assess, treat, evaluate/perform procedures that are appropriate in an urgent or emergency situations
- ✓ Obtain routine medical/nursing care from BTHS medical staff if symptoms of illness occur such as fever, cough, colds, minor or superficial cuts, unusual rashes, breathing problems

This consent will expire one year from the date that I signed this consent.

I would like to be notified before or after care was rendered. If I cannot be reached, please notify the next person on my list:

✓ My information:
Printed name: _____
Relationship to child: _____
Address: _____
Tel No: _____
Employer information:
_____

✓ Other relative(s):
Printed name: _____
Relationship to child: _____
Address: _____
Tel No: _____

Printed name: _____
Relationship to child: _____
Address: _____
Tel No: _____

_____
Child's printed name

_____ _____
Legal guardian/parent's Signature Date signed

Health History

Name of Child: _____ Gender: _____
DOB: _____ Age: _____
Social security number: _____
Race: _____ Ethnicity: _____
Health Insurance:
_____ private _____ Medicaid _____ Self pay

List of medications that child is currently taking including supplements:

1. _____ dose _____
2. _____ dose _____
3. _____ dose _____
4. _____ dose _____

Allergies to food:

1. _____ reaction to food allergy: _____
2. _____ reaction to food allergy: _____

Allergies to medicine:

1. _____ reaction to medicine allergy: _____
2. _____ reaction to medicine allergy: _____
3. _____ reaction to medicine allergy: _____

Medical/mental health history: check all that applies:

( ) asthma ( ) diabetes ( ) juvenile rheumatoid arthritis ( ) cancer
( ) high blood pressure ( ) lupus ( ) anemia ( ) anxiety and depression
( ) other

_____

Surgical history: list all surgeries and the year it was performed:

1. _____
2. _____
3. _____

Other important health information that I want BTHS be aware before they render care to my child:

_____
_____
_____
_____
_____

Privacy Act of 1974: *I understand that these information are necessary for SPSH medical staff in order to care for my child's well-being. I was informed that these information belong to SPSH and will be a part of my child's health record. In addition, SPSH will not disclose or share any of my child's health record to any agency or institution without my consent.*

_____ _____
Legal guardian/parent's Signature Date signed

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON [1] WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

(Before completing this form, please read information on reverse side.)

Name of Student _____ **Birth Date** _____

I (We), _____
have read the Consent Form for the Indian Health to arrange for or to provide the following health services for this child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental care.
3. Mental health services including evaluation and treatment as necessary.
4. Emergency health care for accidents or illness.
5. Transportation of the child to and/or from another health facility for these services.

☐ **I hereby give consent for all of the above services.**

☐ **Exceptions or Special Instructions:** _____

_____

_____

Signed _____

Address _____

Relationship _____

Date _____ **Valid Until:** _____

PLEASE RETURN THIS FORM TO THE SCHOOL

(The third page of this form is for you to keep)

[1] Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

IHS-47
(10/88)

COPY 1 . . . (IHS RECORD)

Only needed if medicine needs to be taken at school.

3416F

Montana Authorization to Carry and Self-Administer Medication

or this student to carry and self-administer medication on school grounds or for school sponsored activities, this form must be fully ompleted by the prescribing physician/provider and an authorizing parent or legal guardian.

tudent's Name:_____ School:_____
ex: (Please circle) Female/Male City/Town: _____
irth date: _____/_____/_____ School Year: _____(Renew each year)

hysician's Authorization:
he above named student has my authorization to carry and self administer the following medication:
:edication: (1)_____ Dosage: (1) _____

(2) _____ (2) _____

:ason for prescription(s): _____
edication(s) to be used under the following conditions: _____

_____

:onfirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his vn with out school personnel supervision. I have provided a written treatment plan for managing asthma or anaphylaxis episodes d for medication use by this student during school hours and school activities.

_____ _____ _____
gnature of Physician Physician's Phone Number Date

Backup Medication – The law provides that if a child's health care provider prescribes "backup" medication to be kept at the school, it must be kept in a predetermined location, known to the child, parent and school staff.

The following backup medication has been provided for this student: _____

r Completion by Parent or Guardian
the parent/guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. /she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self medicate as ed above if needed. If he/she has used an auto-injectible epinephrine, he/she understands the need to alert an adult that emergency dical personnel need to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma ick, he/she is to alert an adult.
so acknowledge that the school district or nonpublic school may not incur liability as a result of any injury arising from the self-inistration of medication by the pupil and that I shall indemnify and hold harmless the school district or nonpublic school and its ployees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and nton conduct, or an intentional tort.
gree to also work with the school in establishing a plan for use and storage of backup medication if prescribed, as above, by my ld's physician. This will include a predetermined location to keep backup medication to which my child has access in the event of sthma or anaphylaxis emergency.
horization is hereby granted to release this information to appropriate school personnel and classroom teachers.
derstand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the physician / re-write the order on his prescription pad and I, the parent/guardian, will sign the new form and assure the new order is attached.
derstand it is my responsibility to pick up any unused medication at the end of the school year, and the medication that is not ed up will be disposed of.

ent/Guardian Signature: _____ Date: _____

iginal signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)