Goodside Health

Health Services Consent Form

District Name _____ **School Name** _____

Please fill out the consent form below to ensure the patient has access to expanded health services at school.

PATIENT INFORMATION

First Name _____ **Last Name** _____

Patient Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Birth Sex: ☐ Male ☐ Female

PARENT/GUARDIAN AND CONTACT INFORMATION

Relationship to Patient:

☐ Self ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Step-father ☐ Step-mother

First Name _____ **Last Name** _____

Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Email _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

If the patient is under 17 years old, confirm that this point of contact:

☐ Can access medical information ☐ Can access billing information

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ADDITIONAL PARENT/GUARDIAN INFORMATION

Relationship to Patient:

☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Step-father ☐ Step-mother

First Name _____ **Last Name** _____

Date of Birth *(MM/DD/YYYY)* _____ **Contact Phone Number** _____

Email _____

If the patient is under 17 years old, confirm that this point of contact:

☐ Can access medical information ☐ Can access billing information

REQUIRED INSURANCE INFORMATION

Goodside Health bills insurance companies to cover the costs of delivering health care services to patients in schools.

Does the patient have health insurance? ☐ Yes ☐ No

If "Yes":

Insurance Provider/Plan Name _____

Member ID Number _____ **Group Number** *(if applicable)* _____

Policy Holder First Name _____ **Policy Holder Last Name** _____

Policy Holder Relationship to Patient _____ **Policy Holder Date of Birth** *(MM/DD/YYYY)* _____

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MEDICAL INFORMATION

Does the patient have any allergies?

Medication Allergies: ☐ Yes ☐ No

Food Allergies: ☐ Yes ☐ No

Seasonal/Environmental Allergies: ☐ Yes ☐ No

If "Yes" for any allergies, please list them: _____

Is the patient currently taking any medications? ☐ Yes ☐ No

Please list: _____

If recommended by a licensed medical provider, the following medications (age/weight appropriate) may be administered to the patient at school:

☐ Approve all ☐ Decline all ☐ Let me choose

- ☐ Tylenol/Acetaminophen *(pain/fever)*
- ☐ Advil/Motrin *(pain/fever)*
- ☐ Hydrocortisone Cream *(inflammation/itch)*
- ☐ Antibiotic Ointment/Bacitracin *(cuts/infections)*
- ☐ Benadryl/Diphenhydramine *(allergic reaction)*
- ☐ Throat Lozenge/Benzocaine/Menthol *(cough, sore throat)*
- ☐ Zofran/Ondansetron *(nausea, vomiting)*
- ☐ Claritin/Loratadine *(allergies, allergic reaction)*
- ☐ Cough Syrup/Dextromethorphan/Guaifenesin *(cough)*
- ☐ Tums/Calcium Carbonate *(upset stomach)*

Has the patient ever had any of the following health conditions or health concerns?

Please select the following:

- ☐ Acid Reflux *(heartburn)*
- ☐ ADD/ADHD *(attention deficit hyperactivity disorder)*
- ☐ Anxiety
- ☐ Asthma
- ☐ Congenital Heart Defect
- ☐ Constipation
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Eczema
- ☐ Genetic Disorder
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Surgery: Type of surgery (*if "Yes"*): _____
- ☐ Other: _____

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PRIMARY CARE PHYSICIAN & PHARMACY

Goodside Health uses this information to coordinate with the patient's doctor and inform them of any Goodside Health visit. Providing telephone and fax numbers will allow Goodside Health to send a visit summary to the patient's physician.

Does the patient have a primary care physician? ☐ Yes ☐ No

Physician's First Name _____ **Physician's Last Name** _____

Physician's Phone Number _____ **Physician's Fax Number** _____

Do you consent to share this health record with your care physician? ☐ Yes ☐ No

What is the patient's preferred pharmacy?

Pharmacy Name _____ **ZIP Code** _____

MENTAL HEALTH PROVIDER

Goodside Health uses the following information to coordinate with the patient's mental health provider and inform them of any Goodside Health mental health visit. Providing telephone and fax numbers will allow Goodside Health to send a visit summary to the patient's mental health provider.

Does the patient have a mental health provider? ☐ Yes ☐ No

Mental Health Provider's First Name _____ **Mental Health Provider's Last Name** _____

Mental Health Provider's Phone Number _____ **Mental Health Provider's Fax Number** _____

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AUTHORIZATION

☐ **I have read the Goodside Health SchoolMed Services Authorization and Privacy policy and I give permission for the patient to receive health care services from Goodside Health providers.**

(Goodside Health SchoolMed Services Authorization and Privacy Practices can be found at https://goodsidehealth.com/terms-conditions/)

☐ **I consent for the patient to receive an annual Well Child Care Visit* from Goodside Health during a Well Care Event at the patient's school.**

*A Well Child Care Visit – also known as a Well Child Check or Child Health Check-up – is a recommended preventative health care service that considers the physical and emotional needs of the patient. Goodside Health will provide Well Child Care Visits at certain participating Schools. With this consent, the patient will receive a Well Child Care Visit if this service is provided at the patient's school.

☐ **I consent for the patient to receive an age appropriate mental/behavioral screening by a Goodside Health healthcare provider.**

_____

Patient Name

_____ _____

Patient or Parent/Guardian Signature **Today's Date**