

**RETURN SIGNED FORMS TO SCHOOL OFFICE OR SCHOOL NURSE**  
**THE HEALTHCARE CONNECTION, INC.**  
**VIKING SCHOOL-BASED HEALTH CENTER (VSBHC)**  
**CONSENT FOR TREATMENT, HEALTH INFORMATION RELEASE, AND PRIVACY FORM**

\_\_\_\_\_  
Print – Student’s Legal Name

\_\_\_\_\_  
Date of Birth

**CONSENT FOR VSBHC SERVICES:**

I, the parent/guardian consent to allow a Viking School-Based Health Center (VSBHC) operated by The HealthCare Connection, Inc. (THCC) to use and disclose my child’s protected health information (PHI) in order to carryout health care treatment, payment and health care operations. I authorize VSBHC staff, the school nurse, and my child’s regular medical provider (if applicable) permission to communicate and share medical information regarding my child’s medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

Confidentiality between the student, parents and VSBHC is assured. I do understand by law, some information requires the student’s signed consent prior to disclosure to anyone, including parents\guardians; and that VSBHC staff will encourage every student to involve his/her parent/guardian in health care decisions. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the VSBHC and the alternative contact. By signing this consent, I understand and agree to the terms and conditions regarding sharing of health information.

**PAYMENT:**

I understand there is a charge depending on the service provided and that I will be responsible for payment. When available, my insurance including Medicaid will be billed. The VSBHC may release information regarding treatment to third party payers for billing purposes. I understand no student will be denied access to VSBHC medical services due to inability to pay.

**HEALTH INFORMATION RELEASE:**

I understand and agree that my child’s health information may be stored in or released through one or more electronic health records systems through which health care professionals and facilities and others involved in my child’s care may view and obtain information. I also understand and agree that, once my child’s health information is released in that way, it may be added into other treating providers’ medical records, and be aggregated with the health information of others and used or disclosed to conduct data analysis, or for any other lawful purpose.

With my consent, the VSBHC may call my home and leave a message on voice mail in reference to any items that assist in providing health care, such as appointment reminders, insurance items, or other items pertaining to my child’s clinical care, including laboratory results among others.

I understand that this Health Information Release Consent applies to information generated prior to the date of this consent and during any subsequent visit while this consent is in effect. This consent is effective on the date of my signature (or the signature of my authorized representative) below. I may revoke this consent in writing, at any time; provided, however, that such revocation will not apply to any uses or sharing of my heath information that occurred prior to the date the written revocation was received.

**Acknowledgement of Notice of Privacy Practices**

I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. I am aware that the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights. I understand that by law, THCC may use or disclose specific information without authorization. Those specific reasons are listed in the Notice. I further understand that my medical information is protected under HIPAA for privacy and confidentiality and cannot be released without my written consent. By signing this form, I am authorizing THCC’s use and disclosure of my protected health information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing.

\_\_\_\_\_  
Signature of Parent or Patient’s Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
For VSBHC use only: Witness signature (only verbal permission obtained by phone)

\_\_\_\_\_  
Date

**RETURN SIGNED FORMS TO SCHOOL OFFICE OR SCHOOL NURSE**

**THE HEALTHCARE CONNECTION, INC.  
VIKING SCHOOL-BASED HEALTH CENTER (VSBHC)  
ENROLLMENT FORM**

Student's Name: \_\_\_\_\_ Student's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Gender: Female  Male

**RACE/ETHNICITY/LANGUAGE** (Please check)

**RACE:**  Asian  Native Hawaiian  Other Pacific Islander  Black/African American  American Indian/Alaskan Native

White  More than one race  Unreported/Refused to report

**ETHNICITY:**  Hispanic or Latino  Non-Hispanic or Non-Latino **PREFERRED LANGUAGE:** \_\_\_\_\_

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**HEALTH CARE SERVICES NEEDED** (Please check and complete all that apply)

Annual physical  Sports physical  Work permit  Immunizations  Sick visit: \_\_\_\_\_

No services needed at this time, please keep consent form on file.

My child regularly goes to another doctor. I would like to use a VSBHC when necessary. I understand my child's doctor will receive reports following visits.

**Preferred Drug Store:** Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

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**CHILD'S INSURANCE INFORMATION** (Please check and complete all that apply)

No health insurance  I wish to apply for a service discount

**Primary Health Insurance:**

Name of Subscriber (Policy Holder) \_\_\_\_\_

Birthdate of Policy Holder \_\_\_\_\_ SS# of Policy Holder \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Phone / Fax Number \_\_\_\_\_

Group & ID Number \_\_\_\_\_

**Secondary Health Insurance:**

Name of Subscriber (Policy Holder) \_\_\_\_\_

Birthdate of Policy Holder \_\_\_\_\_ SS# of Policy Holder \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Phone / Fax Number \_\_\_\_\_

Group & ID Number \_\_\_\_\_

**Medicaid/HMO:**  Buckeye  CareSource  Molina  Paramount  United Healthcare  Other: \_\_\_\_\_

Member Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Medicaid/HMO ID#: \_\_\_\_\_ MMIS # \_\_\_\_\_

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**PARENT/GUARDIAN CONTACT INFORMATION**

Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  Same as child  
Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Okay to leave a message/voicemail or text?  Yes  No Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Okay to email in non-emergency situations?  Yes  No  
 Parent/Guardian responsible for medical bills  
Relationship to student:  Father  Mother  Guardian

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**ALTERNATE CONTACT**

Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  Same as child  
Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Okay to leave a message/voicemail or text?  Yes  No Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Okay to email in non-emergency situations?  Yes  No  
 Parent/Guardian responsible for medical bills  
Relationship to student:  Father  Mother  Guardian

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**CHILD'S HEALTH PROVIDER INFORMATION**

Doctor's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_  
 My child has not had a physical exam within the last year. If time allows, I would like my child to have a comprehensive physical exam during the school year.  
 My child regularly goes to a dentist  
Dentist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_

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**GENERAL INFORMATION**

We accept most commercial insurances, Medicaid, and managed care plans, and also offer discounts to families based on income and family size. For more information about discounted services, or to apply, parents should call The HealthCare Connection's (THCC) Finance Department at **513-483-3078**. No student is denied services due to the inability to pay.

Staff members are available to assist families without insurance to determine eligibility for Medicaid or the federal health exchange. For more information or to request assistance, parents should call **513-483-3071** to speak with a Resource Advocate.

This consent form is valid until your child is no longer a student with the Princeton City School District.

If future health services are needed please call the Viking School Based Health Center to make an appointment.

**Viking Village:** (513) 864-1545

**Heritage Hill:** (513) 864-1402

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**STUDENT HEALTH HISTORY**

**Student Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Sex:**  Male  Female

**Grade:** \_\_\_\_\_

**Date of last physical exam:** \_\_\_\_\_

**Date of last dental exam:** \_\_\_\_\_

**Does your child have any of the following medical problems? Please check.**

Diabetes

Depression

Asthma or Wheezing

ADHD

Seizures

Developmental delay (speech, motor, cognitive)

Other \_\_\_\_\_

Please explain any check marks: \_\_\_\_\_

**Please list any prescription or over the counter medication your child is taking.**

Medication	Dose & Frequency

**Is your child allergic to any medications or food (for example, penicillin, eggs)? If so, please list.**

**Family Medical History**

**Please check if anyone in the child's family has any of the following conditions (include only parents, siblings, grandparents, uncles, aunts, 1<sup>st</sup> cousins):**

Asthma

Heart Disease or Attacks

Diabetes

Environmental Allergies

High Blood Pressure

**Signature of person completing this form:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print Name:** \_\_\_\_\_