Hilltown Community Health Center

School-Based Health Programs
12 Littleville Road
Huntington, MA 01050
413-667-0142
www.hchcweb.org

GATEWAY REGIONAL SCHOOL BASED HEALTH CENTER

Parental/Guardian permission:

For your child to use the School-Based Health Center you must sign the consent form. Services will be provided only with parental consent except for emergency first aid and an initial consultation.
I give consent for:

- My child to receive medical, behavior health, eye care and nutrition services at the School-Based Health Center
- My Child's health information to be shared with the school nurse, guidance counselors, school administrators, his or her primary care provider and other health center or school staff as deemed necessary by the treating provider.
- **NEW THIS YEAR** would you like your child to see the eye doctor? ☐

I authorize:

- A health care provider or other health center staff to give needed examinations, medical tests, evaluations, and management of my child's health in accordance with the law of the Commonwealth of Massachusetts.
- Any referral to my child's primary care provider or specialist concerning needed follow up care.
- The Health Center to release information regarding the care and treatment of my child to any third-party payer for purpose of billing or for any reason that may be required to comply with the status or regulations in accordance with accepted medical, behavior health, eye care or dental practice.

I understand my child:

- Will not receive services, except in an emergency or as allowed by the laws of the Commonwealth of Massachusetts at the Health Center unless a consent form is on file.
- Can receive care using this signed form for the duration of my child's enrollment in the Gateway Regional School District

I understand that I:

- May request in writing for consent to be withdrawn for my child at any time during my child's enrollment in the Gateway Regional School District

_____

Signature of Parent/Guardian Date

This document has two sides. Please turn over to sign the consent form.

Consent Form

*Child's Name*_____*Date of Birth*__/__/___
*Street Address*_____*City*_____*State*____*Zip*_____
*Mailing Address (if different)*_____*City*_____*State*_____*Zip*_____
*Phone Number (____)*_____*Social Security Number*_____
*Email*_____*School*_____*Grade*_____*Staff*_____
*Parent 1 Name/Legal Guardian*_____*Daytime Phone (__)* _____
*Parent 2 Name/Legal Guardian*_____*Daytime Phone (__)* _____
*Emergency Contact Name*_____*Phone number (___)* _____

Race:

American Indian/Alaskan Native ☐ *Asian* ☐ *Black/African American* ☐ *White* ☐
Native Hawaiian ☐ *Other Pacific Islander* ☐ *More than one race* ☐ *Other* ☐

Ethnicity:

Hispanic ☐ *Non-Hispanic* ☐

Language*:*

In what language do you prefer to discuss health related concerns? _____
In what language do you prefer to read health-related materials? _____

Gender Identity:

Male ☐ *Female* ☐ *Transgender Male/Female-to-Male* ☐ *Transgender Female/ Male-to-Female* ☐

Sexual Orientation:

Lesbian or Gay ☐ *Straight (not lesbian or gay)* ☐ *Bisexual* ☐ *Something else* ☐ *Don't Know* ☐

Insurance Information:

*Medical Insurance company*_ _____*Phone Number*_____
*City*_____*State*_____*Zip code*_____
*Subscriber Name*_____*DOB*_____*Social Security# of subscriber*_____
*Policy Number*_____*Group Number*_____*Name of Employer*_____

Medical information:

*Primary Care Physician*_____*Phone Number*_____*Fax Number*_____
*Address*_____*City*_____*State*_____*Zip Code*_ _____
*Pharmacy*_____*Phone Number*_____*City*_____*State*____*Zip Code*_____

***** Please send a copy of your insurance card*****

**Is your child taking any medications or vitamins?* _____
Please check any illness or conditions your child has **EVER had: Anxiety___ Depression___ ADHD___ Autism___*
Anemia ☐ *Asthma* ☐ *Heart Murmur* ☐ *Heart Condition* ☐ *Diabetes* ☐ *Kidney/Liver* ☐ *HIV* ☐ *Rheumatic Fever* ☐
TB___ headaches ☐ *Seizures* ☐ *Concussions* ☐ *OTHER*_____
Does your child have any allergies*? *Yes* ☐ _____ *No* ☐ *if yes check all that apply:
Antibiotics ☐ *Aspirin* ☐ *Foods* ☐ *Latex* ☐ *Resins* ☐ *others* ☐ _____

Your Privacy:

The School-Based Health Center complies with all federal and state privacy regulations (HIPAA). We will use your protected health information only for treatment and billing purposes, and we will obtain your permission before releasing your medical records except as may be required by law.

_____ _____

Student's Name Date of Birth Signature of Parent/Guardian