Revised 01/2021

KU Wichita Pediatrics
Parental Consent Form to Receive Health Care Services

STUDENT INFORMATION

Student's Last Name: ___________________________________
Student's First Name: ___________________________________
Date of Birth: __________/__________/____________
Month Day Year
School attending: ______________________________________

Grade: _____________

Student's Social Security Number: ______________________

Biological sex: ☐ Male ☐ Female ☐ Decline to answer

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____________

Student Address:____________________________________
____
_____________________ _____ _______________
City State Zip Code
Student cell number: ____________________________________

Does the student have a primary care doctor? ❑ Yes ❑ No
If yes, who is the student's primary care doctor?
Name: ____
Telephone: ____
Address: ____
____

PARENT/GUARDIAN INFORMATION

<u>Parent:</u>
Last Name: __________________First Name: _____________
Home Tel: ________________Work Tel: __________________
Mobile: ____
Email: ____

<u>Additional Parent:</u>
Last Name: _________________ First Name: _____________
Home Tel: ________________Work Tel: __________________
Mobile: ____
Email: ____

<u>Legal Guardian (other than parent), If Applicable</u>
Last Name: __________________First Name: _____________
Relationship of legal guardian to student: __________________
Home Tel: ________________Work Tel: __________________
Mobile: ____
Email: ____

<u>Additional Emergency Contact</u> <u>whom I give permission for my student's protected health information to be disclosed:</u>
Name: ____
Relationship to Student: ________________________________
Home Tel: ________________Work Tel: __________________
Mobile: ____

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # __________________________

Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # ________________________________

Which Plan?
❑ Affinity ❑ Fidelis
❑ Healthfirst ❑ Health Plus Amerigroup
❑ HIP ❑ MetroPlus
❑ WellCare ❑ United Healthcare

Does your child have coverage through your employer or any other type of health insurance?
❑ No ❑ Yes, Health Plan: ____________________________
Member ID/Policy Number: ________________________________
Health Insurance Phone: _________________________________

If able, please attach a copy of your insurance card to this form.

PARENTAL CONSENT FOR HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (Health Center Services) and my signature provides consent for my child to receive services provided by the KU Wichita Pediatrics Health Clinic. Parental consent is not required for students who are 18 years or older or for students who are legally emancipated.
<u>NOTE</u>: Per state law, statute 38-123b: "*Notwithstanding any other provision of the law, any minor sixteen (16) years of age or over, where no parent or guardian is immediately available, may give consent to the performance and furnishing of hospital, medical or surgical treatment or procedures and such consent shall not be subject to disaffirmance because of minority. The consent of a parent or guardian of such a minor shall not be necessary in order to authorize the proposed hospital, medical or surgical treatment or procedures*."

X ____ __________________
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X ____ __________________
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

KU Wichita Pediatrics
Parental Consent Form to Receive Health Center Services

HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of KU Wichita Pediatrics and understand this may include learners working under the licensure of the supervising physician, APRN, or PA-C. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Health Clinic services may include, but are not limited to:

1. Screening for vision, hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for infections, anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the health center.
8. Screening questionnaires.

KU Wichita Pediatrics
PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information. This information may be shared for: (1) your student's treatment, including disclosure to school personnel involved in my student's health care including but not limited to the school nurse, health aide, social worker, counselor, and mental health care provider on campus to the extent required to provide quality, comprehensive medical care; and, (2) for billing and payment purposes.

I acknowledge I have received a copy of KU Wichita Pediatrics' Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that KU Wichita Pediatrics may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact KU Wichita Pediatrics's Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my student's health information for the purposes described in the Notice of Privacy Practices.

In addition to the above, information about your student can be shared as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.

Consent to bill insurance and responsible party

I understand that the health clinic needs to cover its expenses and therefore bills for services rendered. This includes billing third parties such as any applicable health insurer. I further understand that as the responsible party for my student, I will be billed directly for health services provided by KU Wichita Pediatrics that are not covered by my by insurer as listed on the reverse side of this form. I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred on behalf of my student not covered by my insurance. If I have concerns regarding billing, I understand that I should contact KU Wichita Pediatrics, Medical Practice Association at (316) 293-3429 and not USD 262 or the school where health services were provided.

Disclosure of Health History

I have reviewed the attached health history form with my student and completed their health history.

____

____

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT