Greater Philadelphia Health Action, Inc.
Medical, Dental, & Behavioral Health Services

Student Health Consent and Authorization Form

Student's Name:	DOB:
School Name:	Grade:
Person Filling Out This Form:	Relation to Student:
Parent/Guardian Name:	Email:
Parent/Guardian Date of Birth:	
Parent/Guardian Primary Telephone #:	Secondary #:
Emergency Contact Name:	Email:
Emergency Contact Phone #:	Relation to Student:

Please read, check, and/or initial the appropriate items below.

Consent For Services (Check all boxes that apply)

- ☐ I hereby authorize and consent for my child to receive **Medical** services by GPHA.
- ☐ I give permission for my child to receive medical services without being accompanied by a parent/guardian.
- ☐ I hereby authorize and consent for my child to receive **Dental** services by GPHA.
- ☐ I give permission for my child to receive dental services without being accompanied by a parent/guardian.
- ☐ I hereby authorize and consent for my child to receive **Behavioral Health** (Mental and/or Substance Abuse Treatment) services by GPHA.
- ☐ I give permission for my child to receive behavioral health services without being accompanied by a parent/guardian.

OR

- ☐ I **do not** want my child to receive any of the above services, unless in an emergency situation.

Initials:_____

Consent to Treat, Treatment Follow-Up, Referrals and Care Coordination

I hereby authorize GPHA and their physicians, dentists, therapists, employees, agents and contractors to deliver or administer the following: medications, immunizations, perform labs and diagnostic procedures, health education, dental screenings, oral health preventive services, behavioral health screenings and interventions. I understand that I will receive a report of findings or recommendations with each encounter/service.

I understand and authorize GPHA dental staff to perform necessary dental screening/preventive services deemed advisable by the dental provider.

I also understand that if additional assessments, treatments or more extensive work/involvement are needed for my child, a referral will be provided to the nearest GPHA location or to any additional agencies/specialists as seen fit by the provider. I also understand in the event of a medical emergency, my child may be sent via ambulance, which may result in an ambulance service related bill.

I understand that if my child has a test result needing immediate attention, has missed follow up appointments or treatments, or has not received medical services consistent with my child's agreed upon treatment plan, I

CONTINUE TO SECOND PAGE

may be contacted at my home, emergency address or any other location by mail, telephone, home/ or hospital visit. If a home/hospital visit is initiated, the reason for the visit will not be disclosed. I understand that only staff trained in protecting patient confidentiality will make home or hospital visits.

I understand that GPHA will provide clinical information to my child's Primary Care Provider (PCP) for continuity of care purposes.

Initials:_____

Medications

In accordance with school-based health services, your child may be able to receive over-the counter medication to relieve discomfort at school. In addition, GPHA may administer or prescribe additional medications. Please list any medications you do not wish your child to have:

_____

I understand that antibiotics, pain relievers and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials:_____

Privacy Practice Notice

I acknowledge having received, read and understood the Privacy Practice Notice as provided by Greater Philadelphia Health Action, Inc. (GPHA). I understand that GPHA will protect my child's health information according to the Federal HIPAA Privacy Rule, which gives patients a right to be informed of the privacy practices of healthcare providers, health plans and of personal health information.

In accordance with state and/or federal law, such as HIPPA, when consent is provided for care, healthcare information is kept confidential and not shared with the school unless permission is given by the student/patient or parent/guardian through a signed release of information. A few exceptions exist: for example, the child has a medical condition that the teacher must be informed of to ensure their well-being in the classroom; the child has a life-threatening health problem and is under 18 years old; there is reason to suspect abuse or neglect; and or/ the child indicates risk of imminent harm to self or others. Also, certain communicable diseases must be reported to public health authorities.

Initials:_____

Additional Notice(s) and Financial Responsibility

Pennsylvania State law permits minors to seek services involving sexually transmitted diseases, pregnancy, contraception, and other reproductive health concerns without prior consent of the parent/ guardian; therefore, this permission form does not apply to these services.

I understand that I am financially responsible for the medical care which my child receives.

Initials:_____

Authorization(s)

☐ I hereby authorize GPHA to release records related to my child's state mandated school health screenings (i.e, immunizations, medical and dental screenings) to Universal Charter Schools. This authorization is valid for one year and will need to be updated yearly thereafter.

I hereby verify that I have reviewed and consent to all of the information above.

Authorized Person (print name)	Authorized Person Signature	Date