Parental Consent and Registration for Services
Mercy Health – Washington Elementary School Health Center

☐ **Yes**, I give permission for my child to receive services provided by the Mercy Health Center at Washington Elementary, a school-based health center (SBHC), and as determined by the Center's medical staff.

- The consent will remain in effect until my child is no longer enrolled in Lorain City Schools or until I revoke consent in writing. It is my responsibility to notify the school about changes in legal guardianship.
- I understand that the SBHC will notify me about seeing/treating my child. This will be done by telephone or in writing.
- I authorize the SBHC and its staff to communicate with my child's doctor/clinic about care/services.
- I authorize the SBHC to bill my health insurance provider for services rendered.

Child/Patient's Name _____**Date of Birth** _____ **SS #** _____
Last First Middle

School _____ **Grade** _____

Child/Patient's Sex_____ **Race/Ethnicity**_____

Parent Phone # _____ Cell # _____ Work # _____

Home Address _____City _____ State _____ Zip Code _____

Parent/Guardian's Name _____**Parent Date of Birth** _____ **Parent SS #** _____
Last First Middle

Child/Patient Allergies (including medications) _____

Emergency Contact (other than listed parent) _____ Relation_____ Phone #_____

Name of Primary Doctor or Clinic _____ Phone # _____

Preferred Pharmacy _____ Phone # _____

Would you like your child's annual well child exam completed at the SBHC? YES NO

Name of Health Insurance or HMO _____

If parent/guardian's policy, insured parent's name and date of birth_____

Medical Card or Insurance Member ID _____ (Please provide a copy of insurance card)

Confidentiality: The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. However, I understand that at times it may be necessary for team members of the SBHC to confer amongst themselves and the school health assistant about health issues related to my child. I understand that, as a courtesy, a record of any service or care to my child at the SBHC will be forwarded to his/her family doctor or clinic. I understand that data not specific to an individual child may be used to evaluate the program.

Signature of Parent or Legal Guardian _____

Date _____

MERCYHEALTH

Mercy Health – Washington Elementary School Health Center
Child Health History

Name of Child _____Date of Birth _____

Please provide the following information, which will help us provide health care to your child. All information will be kept confidential, in accordance with the HIPAA privacy rule.

List Allergies to medications, foods or other things:

_____

Has your child had any operations, hospitalizations, or serious accidents? YES NO
If **YES**, please provide description, dates _____
_____

Did any of the following affect your child? *(please check all that apply)*
___ Problems during pregnancy or delivery
___ Exposure to drugs or alcohol during pregnancy
___ Prematurity
___ Slow development in infancy

Has your child had any of the following illnesses or conditions?
(Please check all that apply and **indicate dates**)

Eyes

	Wears glasses
	Lazy eye
	Pink eye

Ears/Nose/Lungs

	Asthma
	Tuberculosis
	Allergies
	Ear infections
	Strep throat
	Hearing loss
	Household smoking
	Nosebleeds

Mouth/Stomach

	Weighs too much or little
	Frequent stomachaches
	Constipation
	Ulcer
	Diarrhea
	Dental cavities
	Diabetes

Heart

	Heart murmur
	High blood pressure

Skin

	Eczema (very dry skin)
	Rash

Brain/Neurological

	Learning problem
	Behavior problem
	ADHD
	Seizures
	Headaches
	Depression
	Sleep problem
	Speech problem

Bone/Muscle

	Broken bone(s)
	Problems walking

Blood

	Anemia
	Elevated lead level

Does your child take any daily prescribed medications? YES NO
If **YES**, please list _____

Does your child take any over-the-counter medications regularly? YES NO
If **YES**, please list _____

Is your child up to date on immunizations? YES NO DON'T KNOW

(Health History, continued)

Has your child received counseling for any reason? YES NO
If **YES**, when and where? _____

Who is your child's regular doctor? _____

Has your child's doctor recommended any restrictions of activity for your child?
YES NO If **YES**, please list restrictions _____

Would you like your child to have his/her annual well child visit here at the school based health center? YES NO

Family Medical History (please check all that apply)

	Cancer		Diabetes		Heart disease
	Asthma		Allergies		Seizures
	Obesity		Learning disabilities		Mental health problems
	Tobacco use		Alcoholism		Mental retardation
	Stroke		Depression		ADHD
	Migraines		High blood pressure		
	Sudden death related to heart problems in a family member before the age of 50				

Please list all persons living in child's home and relationship to child

_____

_____

_____

_____

Signature of Parent/Guardian _____

Date _____