

**iFM Community Medicine School Health Program
School Parental Consent Form**
Pattonville School District

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of IFM COMMUNITY MEDICINE as part of the school health program approved by the Pattonville School District. 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 pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), 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 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 school-based health center.
8. Vaccines required by the State for school attendance.

Time Period During Which Healthcare Services are Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the St. Louis Public School District

HIPAA Authorization for Use or Sharing of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), your signature may be required in certain circumstances before your health information may be used or shared.

This authorization permits IFM Community Medicine to release certain medical information as stated below. You may refuse to sign this Authorization. You will not be refused health care treatment if you do not sign this Authorization. You may sign this form and later change your mind by sending a letter to IFM. You can request a copy of this form.

IFM Community Medicine may use or disclose my medical information regarding treatment or payment for services. IFM may share information with insurance companies for payment and your primary care provider (if applicable) and others for treatment.

I understand that IFM Community Medicine will make a good faith effort to release only the minimum amount of necessary information needed to carry this out.