Student Name:	Student DOB:	Student School:

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES UNIVERSAL CONSENT FORM

The Cleveland Metropolitan School District ("CMSD") and Say Yes Cleveland ("SYC") partner with many community agencies to offer School-Based Supplemental Health Services. For your convenience, several School-Based providers have agreed to accept a single, Universal Consent Form so that your one-time completion of this form can provide your consent for multiple providers to provide services to your student. Collectively, those providers are referenced throughout this Consent Form as the "Universal Consent Providers." The full list of Universal Consent Providers can be found at the end of this form in Appendix A.

Completion of this consent for treatment form is required for your child to receive supplemental health services from any of the Universal Consent Providers. **School nursing and emergency services will be provided whether or not you choose to take part in these added services**. Some Supplemental Services may not be available at all CMSD school buildings. (Check with your school nurse for questions about services availability).

Student/Patient Information		
Student Last Name: Student First Name:		
Date of Birth:	Sex at Birth (please check): ☐Female or ☐Male	Gender:
Home Address:		City:
State: Zip Code:		Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic (please check)? ☐Yes or ☐ No	
Race (please check): ☐American Indian/Alaskan Native Asian ☐Native American/Pacific Islander ☐Caucasian ☒African American ☐Declined ☐Other:_____		
Name of Primary Care Provider/Physician (PCP):		
PCP Location (please check): ☐Care Alliance - ☐Cleveland Clinic - ☐MetroHealth - ☐Neighborhood Family Practice ☐ NEON ☐UH/Rainbow Babies and Children ☐Other:_____		
Legal Guardian Information		
Guardian's Last Name: Guardian's First Name:		
Date of Birth:		
Home Phone:	Cell Phone:	
Employer:	Employer Phone:	
Student/Patient Insurance Information		
Child/Teen has insurance (please check): ☒Yes or ☐No		
Name of Insurance Company:	Subscriber's Name:	
Group Number:	Subscriber ID:	

Student Name:	Student DOB:	Student School:

Emergency Contact (if we cannot reach you during an emergency, who do you want us to contact?)	
Name:	Relationship:
Phone Number:	May we leave a message? ☐Yes or ☐No

Patient/Student Medical History (to be completed by parent/legal guardian) Please check all that apply.

☐Asthma	☐Cancer/Leukemia	☐Eczema	☐Migraines
☐Premature Birth	☐Sickle Cell	☐Spine Disorders	☐Bladder/Urinary Problems
☐Seizures	☐Glasses/Contacts	☐Hearing Aids	☐Mental Health Issues
☐Blood Disorder	☐Diabetes	☐Pneumonia	☐Kidney/Renal Disease
☐Heart Problem	☐Development Problems	☐Bowel Issues/Constipation	☐Tuberculosis/TB
☐Tobacco Use	☐Substance Abuse	☐Elevated Lead Level	

☐ Other (Please explain):

Patient/Student Current Medications (vitamins, inhalers, prescriptions, other)

Name of Medication	Dose	Amount Taken	Times per Day

Preferred Retail Pharmacy Name:	
Address:	Phone Number:

Patient/Student Allergies

☐**YES** – Please list below:	☐**NO KNOWN ALLERGIES**
Food:	
Medications:	
Insects:	
Seasonal:	
Animals:	

Immunization History

Has your child every had a reaction to any immunizations/shots? ☐Yes or ☐No
If YES, please explain reaction:
What immunization/shot caused reaction:

Patient Hospital/Surgery History

Past Hospital Stays: ☐Yes or ☐No	Explain:
Past Surgeries: ☐Yes or ☐No	Explain:
ER visits in past year: ☐ Yes or ☐No	How many:

Student Name:	Student DOB:	Student School:

Family History (circle all that apply and list who has the problem (mom, dad, grandparent, brother, sister)			
Anemia	☐	High Blood Pressure	☐
SIDS/Sudden Infant Death	☐	Asthma	☐
Headaches	☐	Stroke	☐
Diabetes	☐	Alcohol / Drug Abuse	☐
AIDS/HIV	☐	Cancer	☐
Arthritis	☐	High Cholesterol	☐
Heart Disease	☐	Seizures	☐
Sickle Cell	☐	Tuberculosis/TB	☐
Mental Health Issues	☐	Other (please list)	☐

Universal Consent Providers School-Based Supplemental Health Services Consent Form

The purpose of this Consent Form is to allow parents/guardians/emancipated minors/students over the age of 18[1] to:

(1) give informed consent for your child to participate in and receive treatment from a Universal Consent Provider physician or healthcare provider through the School Health Program with or without the presence of a parent/guardian.

(2) acknowledge that care may be provided in-person or by telehealth. The main difference between telehealth and in-person care is the provider's inability to have direct, physical contact with the patient. Poor-quality telehealth transmission can affect the quality of healthcare services. You may stop using telehealth any time without limiting access to other care, services, or benefits.

(3) acknowledge responsibility for the payment of charges and fees not covered by insurance.

(4) give permission for your child's protected health information ("PHI") to be released from any Universal Consent Provider identified in Appendix A to the CMSD and/or SYC personnel involved in the administration and operation of its health program, including but not limited to nurses, physical therapists, occupational therapists, speech therapists, psychologists, social workers, health coordinators, and School Health Program administrative staff (collectively, "CMSD Health Personnel"), or SYC Family Support Specialists for the exclusive purpose of treatment and care coordination.

(5) give permission for the CMSD and/or SYC to release your child's medical information and other relevant personal information to any Universal Consent Provider identified in Appendix A to facilitate the assessment of your child's health needs, coordinate your child's care, provide treatment or referral, and/or evaluate the School Health Program and the services provided.

Consent for Health Services/Treatment

By signing below, the Parent/Guardian consents for your child to receive, as needed, any of the School-Based Supplemental Health Services listed below (the "Service") from any Universal Consent Provider physician or healthcare provider. The Parent/Guardian understands that examination and treatment may be in-person or by telehealth. The Parent/Guardian understands that he/she can ask and have any questions answered about the risks, benefits, and alternatives of the Services by contacting any of the Universal Consent Providers using the contact information found in Appendix A of this Consent Form. The Parent/Guardian should contact the Universal Consent Providers before signing this Consent Form if he/she has any questions about the Services. The Parent/Guardian acknowledges and understands that by signing this Consent Form, he or she is consenting to the Services and/or immunizations directly below. **If there are services or immunizations you do not want your child to have, please strike out those services below.**

[1] Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/

Student Name:	Student DOB:	Student School:

Services:

(Strike out / cross out any services you DO NOT want your child to receive.)

- ☐Physical exams (well-child, sports, work)
- ☐Care and treatment for injury/illness
- ☐Routine lab tests
- ☐Prescription medications
- ☐Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- ☐Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- ☐Sexual health services (such as reproductive counseling, including contraception)
- ☐Mental/behavioral health assessment and screening
- ☐Dental screening and services (exam, sealants, fluoride), if needed
- ☐Health education and prevention programs
- ☐Sports medicine services
- ☐Mental/behavioral health intervention (additional parental/guardian consent required for children under the age of 18)
- ☐Mental health one-time and ongoing individual counseling
- ☐Mental health one-time and ongoing group counseling
- ☐Drug abuse treatment
- ☐Alcohol abuse treatment
- ☐Vision and hearing screening and follow up services, if needed
- ☐Lead testing / screening

Immunizations (shots):

(Strike out / cross out any immunizations you DO NOT want your child to receive.)

Your school nurse and the School Health Program team will review your child's record to determine which shots are needed.

School-Required Immunizations:

- ☐DTap/Td
- ☐Tdap
- ☐Polio
- ☐Hepatitis B
- ☐MMR (Measles, Mumps, Rubella)
- ☐Meningococcal A
- ☐Varicella (Chicken Pox)

Pediatric/Adolescent Recommended Immunizations:

☐Human Papillomavirus (HPV)
☐Influenza (Flu)
☐Hepatitis A
☐Meningococcal B
☐COVID-19 Vaccine

Please visit **http://www.immunize.org/vis/** to find the Vaccine Information Statement for each vaccine, which will explain risks and benefits of all vaccines.

Agreement of Financial Responsibility

If applicable, the Universal Consent Provider(s) will bill your child's insurance carrier(s) for charges and fees covered by your child's insurance plan. Parent/Guardian agrees to provide complete, accurate, and timely information relating to any available health insurance in order for the Universal Consent Provider(s) to seek payment in a timely manner. Parent/Guardian understands that a failure to provide complete, accurate, and timely information, including any changes

Student Name:	Student DOB:	Student School:

in insurance coverage, may prevent the provider from complying with the administrative rules of your child's insurance plan. Parent/Guardian may obtain a list of usual and customary charges from the Universal Consent Provider(s) upon request.

I, PARENT/GUARDIAN, CERTIFY THAT I AM OF SOUND BODY AND MIND, THAT I HAVE READ THIS CONSENT FORM, THAT I HAVE RECEIVED INFORMATION ON THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, INCLUDING THE PROCESS FOR FILING A COMPLAINT OR GRIEVANCE, THAT I UNDERSTAND AND AGREE WITH THE INFORMATION ABOVE IN THE CONSENT FOR HEALTH SERVICES/TREATMENT AND FINANCIAL RESPONSIBILITY SECTIONS OF THIS FORM, AND THAT I FREELY GIVE MY INFORMED CONSENT FOR MY CHILD TO RECEIVE THE RECOMMENDED SUPPLEMENTAL HEALTH SERVICES.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian:

Relationship to the Child/Student:

Date:

Release of Information

I authorize the Universal Consent Providers to provide my child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to CMSD school officials, including employees, SYC staff, and third parties, engaged in the facilitation of the District's student health and wellness initiatives, for treatment, referral, and/or care coordination. To help coordinate care, I also authorize CMSD and/or SYC to provide a copy of medical information or other relevant personal information within my child's school records to the Universal Consent Providers. I agree to allow the Universal Consent Providers access to my child's individual academic, attendance, and behavior records for the current and prior school years so they can provide better services to my child.

This permission will be in effect from the date of my signature and at any time my child is enrolled in CMSD unless I terminate this authorization in writing.

I understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If you have consented for your child to be tested, treated, or diagnosed with any such injury, disease, or illness, Universal Consent Providers are specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization. For records related to alcohol and drug treatment and/or addiction services, federal law prohibits recipients from making further disclosure of this information unless the additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal law; 42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my child's information, it will not in any way prevent my child from receiving care or treatment from the Universal Consent Providers. I understand that I may terminate this authorization in writing at any time, prior to the release of my child's information, though such termination would not impact information released prior to the submission of a written termination notice. I am also aware there is potential for information disclosed under this consent to be redisclosed by the recipient and no longer be protected.

Notice of Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices if my child is a new patient to any of the Universal Consent Providers. I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for any of the Universal Consent Providers at any of the Universal Consent Providers' program sites if my child has been a patient of the particular

Student Name:	Student DOB:	Student School:

Universal Consent Provider in the past. I know that I can also view them online at the websites identified in Appendix A.

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE MY CHILD'S MEDICAL AND OTHER RELEVANT PERSONAL INFORMATION TO CLEVELAND METROPOLITAN SCHOOL DISTRICT SCHOOL HEALTH PERSONNEL AND THE UNIVERSAL CONSENT PROVIDERS AS DESCRIBED ABOVE.

I, PARENT/GUARDIAN, ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS CONSENT.

THIS CONSENT FORM WILL REMAIN VALID WHILE MY CHILD IS ENROLLED IN THE CLEVELAND METROPOLITAN SCHOOL DISTRICT UNTIL TERMINATED IN WRITING.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____

Date: _____

Student Name:	Student DOB:	Student School:

Appendix A

The Universal Consent Providers covered by the School-Based Supplemental Health Services Universal Consent Form, along with their contact information and Notice of Privacy Practices website are identified below:

Provider Name	The MetroHealth System
Phone Number	216-957-1303
Notice of Privacy Practices	http://www.metrohealth.org/upload/docs/main/Patient%20Visitor%20Information/VII-07BNoticeofPrivacyPractices.pdf

Provider Name	Care Alliance Health Center
Phone Number	216-535-9100
Notice of Privacy Practices	http://www.carealliance.org/wp-content/uploads/2016/05/Notice-of-Privacy- Practices-FY-2016.pdf

Provider Name	Positive Education Program
Phone Number	216-361-4400
Notice of Privacy Practices	https://pepcleve.org/wp-content/uploads/2020/12/Privacy-Practices.pdf

Provider Name	Beech Brook
Phone Number	216-831-2255
Notice of Privacy Practices	https://www.beechbrook.org/client-rights

Provider Name	Applewood Centers
Phone Number	216-459-9827
Notice of Privacy Practices	https://www.applewoodcenters.org/PrivacyPolicy

Provider Name	Neighborhood Family Practice
Phone Number	216-281-0872
Notice of Privacy Practices	https://www.nfpmedcenter.org/notice-of-privacy-practice

Provider Name	Ohio Guidestone
Phone Number	216-513-8073
Notice of Privacy Practices	https://jarvis.ohioguidestone.org/ogsvi/wpcontent/uploads/2020/10/NOTICE- OF-PRIVACY-PRACTICES_OGSHealthPlan2020.pdf

Provider Name	Bellefaire
Phone Number	216-932-2800
Notice of Privacy Practices	https://www.bellefairejcb.org/ManagedFiles/PDF/privacy.pdf