



ANDERSON COUNTY HEALTH DEPARTMENT Consent for School Health Services CHILD / STUDENT INFORMATION

Teacher _____ Grade _____ Team _____
Child's Social Security Number _____
Child's Last Name _____ First Name _____ MI _____
(Please give child's complete legal name)
Birth Date _____
Race _____ Male / Female _____ How many people live in the home? _____
Street Address _____ City _____ Zip _____
Mother _____ Hm Ph _____ Wk Ph _____ Cell Ph _____
Father _____ Hm Ph _____ Wk Ph _____ Cell Ph _____
Legal Guardian _____ Hm Ph _____ Wk Ph _____ Cell Ph _____
Emergency Contact Person OTHER than guardian or parent _____
Home Phone _____ Cell Phone _____ Work Phone _____
Is your child ELIGIBLE for free or reduced lunch? Yes / No / Don't know
Last School Attended _____

My child HAS the following LIFE THREATENING condition that requires EMERGENCY treatment or medications to be given at school.
[] DIABETES [] ASTHMA [] SEIZURES [] SEVERE ALLERGY [] OTHER _____

Child's Medical History
1) Significant medical history: _____
2) Medications taken on a regular basis _____
3) My child has had: Chicken pox disease: Yes / No _____ Chicken pox vaccination: Yes / No _____
4) Allergy to MEDICATIONS _____
5) Allergies to: [] Peanuts [] Bee/Wasp Stings EXPLAIN REACTION: _____
OTHER: _____

Child's Medical Insurance
Does your child have a KY Medicaid Card Yes / No _____ Number (REQUIRED) _____
Does your child have a KCHIP Card Yes / No _____ Number (REQUIRED) _____
Does your child have health insurance Yes/ No _____
Does it cover Immunizations? Yes / No / Don't know _____

Child's Primary Care Physician _____ Child's Dentist _____

Does anyone smoke in your child's home? Yes / No

Consent for Health Services/Assignment of Benefits
I consent to care which may include screenings, exams/physicals, assessments, lab tests, treatment, first aid, over-the-counter medicine, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to release medical /dental information about my child to his/her primary care or dental provider. I also understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to Medicaid/KCHIP so that the Medicaid/KCHIP can be billed for visits to the school clinic. I acknowledge the Anderson County Health Department's Privacy Notice, and will be provided with a copy of this notice if requested.

Signature: _____ Date: _____
(Parent /legal guardian / emancipated student) (EXPIRES ONE YEAR AFTER DATE SIGNED) ACHD 2 (6/11)