Parental/Legal Guardian Consent for Expanded Health Services

Student Name____________________________ Date of Birth__________________Grade_____
Address____Telephone_______________
Parent/Guardian name_________________ Date of student's last physical exam______
Parent E-Mail ___________________________Student E-Mail _____________________
Ethnicity: □Hispanic-Latino/Latina □Non-Hispanic Gender Identity: oMale oFemale Transgender: oMale/Female to Male oFemale/Male to Female
Sexual orientation: oStraight oLesbian/Gay oBisexual oSomething else oDon't know oChoose not to disclose
Race: check all that apply: □American Indian/Alaska Native □Asian □Black/African American □White □Native Hawaiian or other Pacific Islander □Other Race ______

- I give permission for my son/daughter to receive health care services at the Blue Devil Health Center. I understand this permission will remain in effect until November 1, 2022, unless permission is withdrawn by me in writing.
- I understand that by signing this consent, my student may access any of the following services at the Health Center and that confidentiality laws protect information concerning reproductive and behavioral health care:
    - Medical services provided by Dr. Larry Newman and St. Croix Regional Family Health Center
  - Physical exams such as sports and college physicals, including annual strengths and risks assessments
  - Diagnosis, treatment and triage of injuries (for example, a sprained ankle)
  - Diagnosis and treatment of minor illnesses and infections (for example, strep throat, pink eye)
  - Evaluation of symptoms such as headaches or stomach pain
  - Management of chronic diseases (asthma, diabetes, etc.) in collaboration with my student's primary care provider or specialist
  - Age-appropriate reproductive healthcare and life planning, preventive and abstinence education, pelvic exams, treatment of STDs, pregnancy testing, prescriptions, and referral
  - Urine tests, hemoglobin tests, strep and mono screening, serum glucose testing
  - Written prescriptions if appropriate
  - State provided immunizations
  - Mental health services (as available) including counseling provided by AMHC/Sunrise Opportunities
- I understand that Maine State Law requires a parent or legal guardian's consent to provide medical treatment to an individual under 18 years of age (if not an emancipated minor), except for services related to reproductive health, mental health, or substance abuse.
- Medical records and information are protected under HIPAA. However, I acknowledge that the Health Center may release information regarding treatment to third party payers, such as MaineCare, for the purpose of billing and for any reason in accordance with acceptable medical practice and pursuant to law.

______________________________ ___________________ _____________
Parent or legal guardian signature Daytime phone Date

STUDENT NAME________________________________Date of birth_________________
Family size ______ Income (Please select one)
___ $0-$20,000 ____$20,001-$40,000___$40,001-$60,000____$60,001-$80,000___$80,001 +

Insurance Information

Please attach a photocopy of your insurance card, if possible.

My student is covered by:

- ❑ No insurance
- ❑ MaineCare (Medicaid): Child's I.D. # _________________________________
- ❑ Private Health Insurance:
  - Insurance Company Name______________________________________
  - Insurance type____
  - Insurance Company Address____________________________________
  - Insurance Company Phone______________________________________
  - Child's policy #____
  - Group #____
  - Name of policy holder (insured)_________________________________
  - Date of birth of policy holder__________________________________

HIPAA Compliance and Consent to Release Information to Insurance Carrier

The Blue Devil Health Center complies with Federal Laws related to the use and release of individually identifiable health information. Policies and procedures related to HIPAA compliance may be obtained at any time at the center. I acknowledge this information and authorize release of medical and related information obtained in the course of diagnosis and treatment to my insurance company or other third party payer for the purpose of obtaining payment for services rendered. This authorization excludes information that is protected under Maine State minor consent laws. Authorization may be withdrawn at any time by written notification.

____ ________________
Signature Date

Consent to Release Information to Primary Care Provider (Doctor or Nurse Practitioner)

Student's primary care provider:______________________________

I understand that School Health Center services are meant to compliment and not replace those services provided by my student's primary care provider and that all health-related information will be treated in a confidential manner. I authorize the Blue Devil Health Center to both release and receive information from my student's primary care provider as necessary to provide care. This release of information shall be in effect throughout the student's enrollment, unless revoked in writing. This consent does not include privileged information concerning treatment for substance abuse, sexually transmitted disease, HIV status, or mental health issues.

____ ________________
Signature Date