Health Partners of Western Ohio - Toledo Public Schools

Patient Information/Consent to Treatment & Release of Information

Student/Patient Information		
Student/Patient Name:		
Date of Birth:	Sex (please check one): ☐ Female ☐ Male ☐ Unspecified	Social Security #:
Home Address:		City:
State:	Zip code:	Phone Number:
School Name:		
Ethnicity (please circle): American Indian/Alaskan Native Asian Native American/Pacific Islander Caucasian African America Decline Other:		
Name of Primary Care Provider (PCP):		

Legal Guardian Information	
Guardian's Name:	
Date of Birth:	Social Security #:
Home Phone:	Cell Phone:

Student/Patient Insurance Information	
Student/Patient has insurance (please circle) Yes or No	
Name of Insurance Company:	MMIS Number:
ID Number:	Group Number:

Emergency Contact Information		
Name:	Relationship:	Phone Number:

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

Name of Medication	Dose	Amount Taken	Times per Day

Preferred Pharmacy	
Address:	Phone Number:

Student/Patient Allergies	
☐ **YES** - Please list below	☐ **NO** Known Allergies
Medication:	Food:
Insect/Animal:	Seasonal:

Student/Patient Hospital/Surgery History
☐ **NO** ☐ **YES** - Please provide reason and dates:

Student Name:	Student Date of Birth:
Family History list who has health problem next to the problem (ex: mom, dad, sibling, or grandparents)	
Anemia:	High Blood Pressure:
Diabetes:	Asthma:
Heart Disease:	Stroke:
Sickle Cell:	Cancer:
Mental Health:	Other:

Patient/Student Health History (please check all that apply)

☐ Asthma	☐ Cancer/Leukemia	☐ Migraines
☐ Mental Health (ex: ADHD, depression, anxiety)	☐ Premature Birth	☐ Sickle Cell
☐ Bladder/Urinary Problems	☐ Blood Disorders	☐ Seizures
☐ Kidney/Renal Disease	☐ Spine Disorders	☐ Glasses/Contacts
☐ Bowel Issues/Constipation	☐ Diabetes Mellitus	☐ Hearing Aid

☐ Other: _____

Consent for Treatment and Release of Information

I _____(parent or legal guardian) hereby acknowledge that as a parent or legal guardian, I have given my consent to Health Partners of Western Ohio Health Center to administer such primary care as is appropriate and as indicated to _____(student's name), a minor child. I understand this care may include, but not be limited to sports/work physicals, minor injuries, immunizations, health screenings, preventative care, routine sick visits, behavioral health services, dental exams and dental procedures.

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when student/patient is located at a different site than the provider. I herby consent to the provision of health care services via telemedicine when the provider is off site. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.

I also extend this consent to allow the release of health information that Health Partners of Western Ohio considers appropriate, to any medial facility or provider who may require same to treat the student or for the purpose of collecting insurance. This consent includes releasing information regarding any health visits to the staff nurse at the location referring the child.

If health information is released to a medical facility or provider, would you like to be notified? ☐ Yes or ☐ No

Obtaining care through Health Partners of Western Ohio does not require changing your student's regular provider.

If you have health insurance, your health insurance will be billed for services. If you do not have health insurance, you will be responsible for the bill at the appropriate discounted fee. You might qualify for a discounted fee. No student/patient will be denied care due to inability to pay for services. We can help you if you need assistance applying for insurance. You can stop into our center or give us a call.

I understand this consent will remain valid as long as my child remains a student within Toledo Public Schools unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that the school based health services remove my child from services. If my child is not enrolled in Toledo Public School, this consent is valid for one calendar year from the date signed.

I have read and fully understand the statement above.

_____ _____

Parent or Legal Guardian (Signature) **Date**