Hopkins County HEALTH DEPARTMENT

Consent 23-24

GENERAL INFORMATION

Please complete the following information for student (**front and back**)
(**PLEASE PRINT**)

Last Name_____ First Name _____ Middle Name_____

Student's Social Security # _____ Date of Birth _____ Gender: **Male / Female**

Mother's name _____ (maiden name) _____ cell #_____work # _____
Father's name _____ cell #_____work # _____
Address_____
PO Box/Street City Zip
Parent's email _____Home phone #_____Student's Cell #_____

How many people live in your house? _____

Who does the child live with?
Name _____ Relationship _____ Phone #_____

Race (mark all that apply) Native American ___ Asian___ Black or African American___
Native Hawaiian or Other Pacific Islander___ White___ **Is student Hispanic Y / N or Latino Y / N**

Do you speak English? **Y / N** If no, what is the primary language? _____

*** If my child has symptoms of COVID-19, I give permission for the RN to administer a Rapid COVID-19 TEST? Yes or No**

Is student covered by Kentucky Medicaid? **(Medical Card) Y / N**
If applicable, circle MCO: AETNA / Well Care / Humana / Anthem / Molina-Passport / United Healthcare
Policy # as listed on Medicaid or MCO card: _____

Does student have private health insurance? **(Not Medicaid) Y / N** Name of Insurance _____
Does insurance cover ALL immunizations? **Y / N If not, which ones are not covered?** _____

Name of child's primary care doctor_____ phone #_____

Is student in foster care? **Y / N (If yes, DCBS must sign consent) Case Worker** _____**Phone #**_____

In case of an EMERGENCY, if unable to contact a parent/guardian, please provide at least 3 other people we can contact.
(This should be same as school information - Please contact school clinic if phone numbers change)

Name	**Relationship to student**	**Best Contact #**
1.		
2.		
3.		

What grade will your child be in during the 2023-2024 school year? _____

Who is your child's homeroom teacher for the 2023-2024 school year? _____

If your child is in Preschool or Head Start, are they in the AM or PM class? _____

Sign on back ➡

Please answer yes/no to the following questions. If the answer is yes - please explain.

1. Allergies **(medications, food, latex, etc.)** **Y / N** _____

_____

Does your child require an EPI-PEN for his/her allergy? Y / N

2. Current medication(s) **Y / N** _____

Are there any over-the-counter medications your child should NOT take? _____

3. Past surgeries/hospitalizations/transfusions **Y / N** _____

4. Has your child had chicken pox? **Y / N** If yes, date diagnosed: _____
   Was it diagnosed by a healthcare provider? **Y / N**

4. Long-term illnesses **Y / N** _____

5. Other concerns **Y / N** _____

6. Does anyone smoke inside the home or car? Y / N Are E-cigarettes/Juuls smoked inside the home or car? Y / N

7. Has your child been in contact with a person with tuberculosis or has your child traveled to or emigrated from a foreign country with a high rate of TB (Asia, Middle East, Africa, or Latin America)? **Y / N** _____

8. Has your child had exposure to the following risk factors for lead poisoning: peeling paint in a house built before 1978, a close family member with lead poisoning, a family member with an occupation that has lead exposure, living closely to a highly traveled highway, using folk remedies containing lead, eating food stored in old pottery, chewing on paint chips or eating dirt? **Y / N** _____

Family history (student's parents, grandparents, siblings): diabetes, stroke, elevated blood pressure, heart disease, TB, cancer, kidney disease, seizures, sickle cell, genetic/birth defects, HIV, or mental health problem(s)

_____

_____

CONSENT TO HEALTH SERVICES

I give my consent for _____ to receive services at the Hopkins County
(Student's Name) (Birth Date)
Health Department School-Based Clinic. Services might include: required school examinations, TB skin test, lead & urine test for Head start students, first aid, Well Child exam or preventive dental screening. This consent will include permission to receive over-the-counter medications such as: Tylenol, Tums, decongestants, cough medicine, anti-nausea medicine, Ibuprofen, antihistamines, etc. I verify that I have received notice of privacy practice. ***If Applicable***, I authorize billing for Medicaid services.

_____ _____

Signature of Parent/Guardian **Date**

(If student is in foster care, consent must be signed by DCBS Case Worker)
(If you have custodianship of student, we need a court order, notarized Power of Attorney or notarized Caregiver Affidavit)

Student should return form to homeroom teacher or school clinic. Consent is for the 2023-2024 school year.

Child cannot be seen in the school clinic without a signature from the parent, legal guardian, or Community Base Services' (DCBS) case worker.