North Country HealthCare
Mobile/School Based Services
Parental/Patient Consent Form
2920 N. 4th Street, Flagstaff, Arizona 86004

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
Student's School/Grade:_____ **Student's Last Name**: _____ **Student's First Name**: _____ **Date of Birth**: _____/_____/_____ *Month Day Year* **Student's Social Security Number:** _____ **Sex**: ❑ Male ❑ Female **Student's Address**: _____ _____ _____ _____ _____ *City State Zip Code* **Student's regular doctor?** Name: _____ Telephone: _____ Address: _____ ***NCHC will share health information with your child's primary care physician.**	*For Students younger than 18 years old:* **Parent/Legal Guardian:** Name: _____ Date of Birth: _____/_____/_____ Relationship to student: _____ Home Tel: _____Work Tel: _____ Cell: _____ **Ok to leave a detailed message at these #'s ?** ❑ Yes ❑ No **Additional Emergency Contact** Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____ Cell: _____

INSURANCE INFORMATION

Does your child or you, if 18 years or older, have Private or AHCCCS insurance? ❑ Yes ❑ No **If "Yes" complete below:**

Insurance Name: _____

Subscriber/Policy Holder : _____

Group Number: _____

Subscriber/Policy Number : _____

If your child does not have health insurance coverage, would you like to be contacted by a representative of North Country HealthCare regarding a Sliding Fee Scale option?
❑ No ❑ Yes

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HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

SCHOOL BASED HEALTH CENTER SERVICES
NORTH COUNTRY HEALTHCARE
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be shared between North Country HealthCare and FUSD (FLAGSTAFF UNIFIED SCHOOL DISTRICT), either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time. Revoking my authorization for medical release will require a written request to North Country HealthCare. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the North Country HealthCare School-Based Health Services Program-Mobile Unit to release specific medical information of the student named on the reverse page to FUSD (FLAGSTAFF UNIFIED SCHOOL DISTRICT)

I consent to the release from North Country HealthCare to Flagstaff Unified School District of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law.

Information Required by Law:
- Immunizations

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment
- Health insurance coverage

My consent signature on this form also authorizes North Country HealthCare to contact other providers that have examined my child and to obtain insurance information.

<u>Time Period During Which Release of Information is Authorized</u>:

From: _____ Date that form is signed on opposite page
To: _____ Date that student is no longer enrolled in the school-based health care program with North Country healthcare and FUSD

Approved 10/12/21

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Screening:	**YES**	**NO**	
1. Is your child feeling sick today?			
2. Has your child ever received a dose of COVID-19 vaccine? If so, when?			
3. In the last 60 days, has your child had a positive COVID-19 test or do you have a pending COVID-19 test?			Date positive if known_____
4. Has your child been told to quarantine for COVID exposure in the past 14 days?			Date of known exposure:
5. Has your child been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did they receive their last dose?			
6. Has your child ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or injectable medication?			
7. Has your had any vaccines in the past 14 days (2 weeks) including flu shot +? If yes, how long ago was your most recent vaccine?			
8. Does your child have any medical condition that has compromised their immune system?			
9. Does your child take any medications that affect their immune system, such as cortisone, prednisone, or other steroids, anticancer drugs, or radiation treatments? If yes, describe:			____Chronic ____Short Term
10. Is there any further medical information you would like us to know about your child? If so, please list _____			

---------- FOR STAFF USE ONLY----------

VACCINE	MGF	LOT # and Expiration Date	SITE	ROUTE	DOSE
Pfizer-BioNTech COVID-19 Vaccine	Pfizer 1st dose		RD LD LT RT	IM	0.3 mL
	Pfizer 2nd dose		RD LD LT RT	IM	0.3 mL
	other				

Notes:_____

Administrator's Signature _____ Title _____

Date administered _____/____/_____

Approved 10/12/21