# Nurse Office Consent for Treatment/Emergency Information ~~Form~~

## OVER THE COUNTER MEDICATIONS

The following are available to all students whose consent forms have been signed/returned:

**Over the counter medications following assessment by School Nurse if available.**

**Cross out any over the counter medications below you DO NOT want your child to receive.**

Acetaminophen (Tylenol)
Ibuprofen (Motrin)
Midol (only for students age 12 and older)
Tums
Cough Drops/Throat Lozenges
Diphenhydramine (Benadryl) only for allergic reactions
Topical Antiseptic (Benzalkonium Chloride)
Hydrogen Peroxide
Lip Ointment (Chapstick/Carmex/Blistex/Vaseline, etc.)
Lotion
Hydrocortisone Cream 1%
Burn Cream
Sting Relief Swabs
Topical mouth/tooth pain relievers (Orajel/Anbesol)
Antibiotic Ointment (Neosporin/Bacitracin, etc.)
Eye Wash, Irrigating Solution

**Reminders:**

- The medications listed above will **only be given by licensed medical personnel** (Licensed Practical Nurse [LPN], Registered Nurse [RN], and/or Advanced Practice Registered Nurse [APRN]) when they are available in the building.
- Unlicensed school staff cannot give any of these medications, they may only be given by licensed medical staff.
- No other District employee may give these medications. These medications cannot be given for more than three (3) days in a row without a note from your child's health care provider.

## OTHER SERVICES PROVIDED BY SCHOOL NURSES:

**Health Assessments:**

- Nursing assessment of health complaints, nursing management, and referral as needed.
- Hearing Screenings
- Dental Screenings
- Vision Screenings
- Immunization Outreach and Follow-Up
- Preventive Health Exam (APRN)

**Health Education Services:**

- Physical Health Conditions
- Physical and Dental Health Education
- Classroom Instruction per request as time allows
- School Health Plans:

## PLEASE CONTACT YOUR SCHOOL NURSE IF NEEDED

**(Check if your child has any of the following):**

☐ Asthma
☐ Dietary Needs (including food allergies)
☐ Allergy to something other than food
☐ Other Health Conditions (for other conditions not listed above)
☐ Diabetes
☐ G-Tube
☐ Seizure

School Nurses also provide care coordination by working with students, parents, and healthcare providers to manage chronic health needs.

## CONFIDENTIALITY:

All medical records are the property of District and protected under FERPA. No other agency will have access to these records without your written consent. We protect the privacy of your child's health information by:

- Limiting how we use and disclose health information.
- Providing physical safeguards (secure offices and storage facilities, electronic protections, and procedures.
- Training employees about privacy policies and procedures.

# Nurse Office Consent for Treatment/Emergency Information

## Please Return to School

Reviewed by: _____
Entered: ☐

**CHILD/STUDENT INFORMATION**

Grade _____ Homeroom Teacher _____

**Child's** Last Name _____ First Name _____
(Please give child's complete legal name)

**Child's** Birth Date _____ ☐ Male ☐ Female

Street Address _____ City _____ Zip _____

Parent _____ Phone # 1 _____ Phone # 2 _____

Parent _____ Phone # 1 _____ Phone # 2 _____

Legal Guardian _____ Phone # 1 _____ Phone # 2 _____

Emergency Contact Person **OTHER** than parent or guardian _____

Emergency Contact Person Phone # 1 _____ Phone # 2 _____

**Has your child EVER attended a Newport Independent School?** ☐ Yes ☐ No
**If YES, what School (s) did student attend in the past?** _____

My child HAS the following **life threatening condition** that may need EMERGENCY TREATMENT or MEDICATION (Epi-Pen, Glucagon, Emergency Seizure medications, Asthma Inhaler, etc.) at school:

☐ **Diabetes** ☐ **Asthma** ☐ Seizures ☐ **severe** allergies ☐ **Other:** _____

**Is your child ALLERGIC to:** (Check all that apply)

☐ **Medications:** Please LIST: _____

☐ **Peanuts:** EXPLAIN REACTION: _____

☐ **Tree Nuts:** EXPLAIN REACTION: _____

☐ **Bee/Wasp Sting:** EXPLAIN REACTION: _____

☐ **Other:** EXPLAIN REACTION: _____

**CHILD'S Other Medical History** (Heart Conditions, Cancer/Blood Disorders, Behavior Emotional, G-Tube, etc.):

Important medical history that staff should know about: _____

_____

**Medications taken every day:** _____

**CHILD'S MEDICAL Insurance:**

Does your child have a KY Medicaid Card? ☐ Yes ☐ No Medicaid Number: _____

Other Health Insurance? ☐ Yes ☐ No Insurance Name: _____
Number _____

**Child's** Health Care Provider: _____ Phone # _____

**Child's** Dentist: _____ Phone # _____

**CONSENT FOR HEALTH SERVICES**

I consent to care for my child that may include screenings, exams, assessments, treatment, first aid, over-the-counter medications as listed on the Consent for Treatment form, and any other health services given to me/my child by staff/licensed volunteers of this School Health Office. 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 Office to receive and release medical/dental/immunization/vision information about my child to his/her individual school, healthcare provider, immunization registry, dental or vision provider as needed or requested.

**Signature:** _____ **Date:** _____
(Parent/Guardian) (Expires in one [1] year)

A substantially equivalent electronic form may be used by the District in lieu of this paper form.

## Nurse Office Consent for Treatment/Emergency Information

The Christ Hospital in Cincinnati has partnered with Newport Independent School District to provide care for students and staff district-wide in a School Based Health Clinic (SBHC) located inside the Intermediate school.

This form will serve as a CONSENT TO TREAT YOUR STUDENT, or yourself if you are a staff member, at the SBHC.

Student/Staff Name: _____ DOB: _____
Address: _____ Gender: _____

List any health conditions, previous surgeries, routine medications, allergies to medications, or significant historical information that you would like to share with the Nurse Practitioner at this time:

_____

_____

_____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

☐ I have received a copy of the Notice of Privacy Practices.
☐ I have previously received a copy of the Notice of Privacy Practices.
☐ I do not want a copy of the Notice of Privacy Practices.

**AUTHORIZATION OF MEDICAL AND RELATED HOSPITAL SERVICES**

**1. CONSENT TO TREATMENT:** I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by The Christ Hospital Physician Division or assistants or designated as may be needed. I understand that the Christ Hospital is a teaching hospital and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.
**2. RELEASE OF RECORDS:** I authorize the release of medical records information (including but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be related to state, federal or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency for my follow-up care, and/or to the healthcare facility to which I am transferred from The Christ Hospital. I authorize the Christ Hospital Physician Division to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with The Christ Hospital Physician Division's system. I also authorize release of my medical record information as required or permitted by law.
**3. NOTICE:** I understand that certain physicians providing services to me, including Radiologists and Pathologists are independent contractors not employed by the hospital, and that I will be billed by the individual physician for services rendered to me by these physicians.
**4. FINANCIAL AGREEMENT:** I hereby authorize The Christ Hospital to submit a claim to my insurance carrier(s) or its intermediaries to issue payment DIRECTLY to the Christ Hospital on behalf of such rendered services. I understand that I am financially responsible to The Christ Hospital for any balance not covered by my insurance carrier.
**5. COMMUNICATING WITH YOU:** Consent to contact by electronic and other means. The Christ Hospital Physician Division, its employees, its affiliates, and the vendors, agents, contractors, collectors, successors, and assigns of The Christ Hospital Physician Division and its affiliates (collectively, "TCHP"), may contact me for any lawful reason, including for the collection of amounts owed to TCHP and for the offering of products or services in compliance with applicable privacy policies and requirements that are in effect from time to time. No such contact will be deemed unsolicited. By signing below, I authorize and voluntarily consent to TCHP contacting me: (i) at any address (including email) or telephone number (including wireless cellular telephone or ported landline telephone number) that I provide, have provided, or that was provided on my behalf to TCHP; (ii) using any means of communication (including but not limited to postal mail, electronic mail, telephone, text, messaging or other technology) to reach me; and (iii) using automated dialing systems and announcing devices and playing recorded messages.

I understand that I may contact The Christ Hospital HIM/Medical Records Department to ask that TCHP not contact me using any one or more methods or technologies by writing to us at 2139 Auburn Avenue, Cincinnati, OH 45219, calling us at 513-263-8660 or by any other reasonable means. I understand that my receipt of healthcare treatment and services is not conditioned upon my agreement to this provision.

_____ _____
SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF PATIENT IS A MINOR Date

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## Nurse Office Consent for Treatment/Emergency Information

El Christ Hospital en Cincinnati se ha asociado con Newport Independent School District para proporcionar atención a los estudiantes y el personal de todo el distrito en una Clínica de Salud Basada en la Escuela (SBHC) ubicada dentro de la escuela Intermedia.

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Este formulario servirá como consentimiento para TRATAR a SU ESTUDIANTE, o a sí mismo si usted es un miembro del personal, en el SBHC.

Nombre del alumno/personal: _____ DOB: _____

Dirección: _____ Género: _____

Enumere cualquier condición de salud, cirugías previas, medicamentos de rutina, alergias a los medicamentos o información histórica significativa que desee compartir con el profesional de enfermería en este momento:

_____

_____

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### ACUSE DE RECIBO DE AVISO DE PRÁCTICAS DE PRIVACIDAD (LEY HIPAA)

La ley nos exige que le entreguemos una copia de nuestro AVISO DE PRÁCTICAS DE PRIVACIDAD la primera vez que usted recibe atención en TCHP. Si está aquí por tratamiento médico de emergencia, se le entregará una copia lo antes posible del Aviso de Prácticas de Privacidad

☐ Recibí una copia del Aviso de Prácticas de Privacidad.

☐ Recibí una copia del Aviso de Prácticas de Privacidad antes.

☐ No quiero una copia del Aviso de Prácticas de Privacidad.

### AUTORIZACIÓN DE SERVICIOS MÉDICOS Y RELACIONADOS CON EL HOSPITAL

**1. CONSENTIMIENTO PARA TRATAMIENTO:** Doy mi consentimiento para la administración de tratamiento médico, de enfermería o de otro tipo, terapia con fármacos y/o pruebas, según se considere necesario para mi afección según las indicaciones The Christ Hospital Physicians o asistentes o personas designadas, según sea necesario. Entiendo que The Christ Hospital es un hospital de enseñanza y acepto que médicos internos, médicos residentes, médicos en especialización, enfermeros, estudiantes médicos y otro personal de la salud en capacitación participe o ayude a mis médicos en los procedimientos/tratamientos médicos, quirúrgicos o de diagnóstico que mis médicos consideren necesarios.

**2. DIVULGACIÓN DE REGISTROS:** Autorizo a divulgar información de registros médicos (incluyendo, pero sin limitarse a información relacionada con afecciones relacionadas con drogas, alcoholismo, afecciones psiquiátricas, pruebas de VIH, diagnóstico/afecciones relacionadas con SIDA) a aseguradoras, terceros pagadores o a sus representantes y/u organizaciones supervisoras, según se considere necesario para determinar el derecho a recibir beneficios y para procesar los reclamos de pago para los servicios de salud proporcionados. También entiendo que mis registros se pueden divulgar a supervisores estatales, federales o de otro tipo para propósitos relacionados con acreditación y/o regulaciones para la licencia. Autorizo la divulgación de información del registro médico a los médicos o a la para mis cuidados de seguimiento, y/o al centro de cuidados de la salud al que soy transferido/a desde The Christ Hospital. Autorizo a The Christ Hospital Physicians a acceder, divulgar y compartir información médica electrónica accesible con otros proveedores médicos que usen un sistema de registro médico electrónico compatible con el sistema de The Christ Hospital Physicians. También autorizo a divulgar la información de mi registro médico según lo requieran o permitan las leyes.

**3. AVISO:** Entiendo que ciertos médicos que me proporcionan servicios, incluidos los médicos radiólogos y patólogos, son contratistas independientes que no son empleados del hospital, y que los médicos individuales me enviarán una factura por los servicios que esos profesionales médicos me brindaron.

**4. ACUERDO FINANCIERO:** Autorizo a The Christ Hospital a presentar un reclamo a mi(s) aseguradora(s) o a sus intermediarios para emitir un pago DIRECTAMENTE a The Christ Hospital por los servicios brindados. Entiendo que soy responsable financieramente ante The Christ Hospital por los saldos que no estén cubiertos por mi aseguradora.

**5. COMUNICACIÓN CON USTED:** Consentimiento para contactar por medios electrónicos y de otro tipo. The Christ Hospital Physicians, sus empleados, sus afiliados y los proveedores, agentes, contratistas, cobradores, sucesores y personas asignadas de The Christ Hospital Physicians y sus afiliados (en conjunto, "TCHP"), pueden contactarme por cualquier motivo legal, incluyendo el cobro de montos que se deban a TCHP y para ofrecer productos o servicios, cumpliendo las políticas y requisitos de privacidad correspondientes que estén vigentes oportunamente. Dichos contactos no se considerarán no solicitados. Al firmar más abajo, autorizo y doy mi consentimiento voluntariamente para que TCHP me contacte: (i) en cualquier dirección (incluyendo correo electrónico) o número de teléfono (incluyendo celular inalámbrico o teléfono fijo) que proporcione, haya proporcionado o que se haya proporcionado en mi nombre a TCHP; (ii) usando cualquier medio de comunicación (incluyendo, pero sin limitarse a correo postal, correo electrónico, teléfono, texto, mensaje u otra tecnología) para contactarme y (iii) usando sistemas de discado automatizado y dispositivos de avisos y mensajes grabados.

Entiendo que puedo contactar al encargado de información de salud (HIM, en inglés) o al Departamento de Registros Médicos (Medical Records Department) de The Christ Hospital para pedir que TCHP no se comunique conmigo usando cualquier método o tecnología o escribiendo a 2139 Auburn Avenue, Cincinnati, OH 45219, llamando al 513-263-8660 o por cualquier otro medio razonable. Entiendo que el recibir tratamiento y servicios para el cuidado de mi salud no está condicionado a mi aceptación de esta disposición.

_____ _____

FIRMA DE PACIENTE (si tiene 18 años o más) O TUTOR LEGAL SI EL PACIENTE ES MENOR Fecha/Hora

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**Student's Name** _____
*Last Name* *First Name* *Middle Initial*

**Student's Address** _____
*Street Address/Apt. #* *City* *State* *Zip Code*

**Student's Age** _____ **Date of Birth** _____ **Student's Phone Number** _____

**Grade** _____ **Teacher (Homeroom)/Classroom** _____ **Bus #** _____

TO BE COMPLETED BY PARENT/GUARDIAN: TO SERVE YOUR CHILD IN CASE OF ACCIDENT OR SUDDEN ILLNESS, IT IS NECESSARY THAT YOU FURNISH THE FOLLOWING INFORMATION:

**MOTHER'S NAME** _____
*Last Name* *First Name* *Middle Initial*

Mother's Employer _____ Phone # _____

**FATHER'S NAME** _____
*Last Name* *First Name* *Middle Initial*

Father's Employer _____ Phone # _____

**GUARDIAN'S NAME** _____
*Last Name* *First Name* *Middle Initial*

Guardian's Employer _____ Phone # _____

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the following people who are authorized to pick up my child from school or a school-sponsored activity:

_____
*Name* *Phone Number* *Relationship*

_____
*Name* *Phone Number* *Relationship*

Doctor's Name: _____ Phone # _____

Address: _____

If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

_____
*Signature of Parent/Guardian* *Date*

## Emergency Information Form

Is your child on any routine medication? ☐ Yes ☐ No If yes, please list below:

| Medication | Dosage |
|---|---|
| | |
| | |
| | |
| | |

Is your child allergic to medication(s)? ☐ Yes ☐ No If yes, please specify _____

Is your child allergic to insect bites? ☐ Yes ☐ No

Does your child have allergies? ☐ Yes ☐ No

Does your child have a history of ☐ heart disease ☐ diabetes ☐ T.B ☐ nervous disorder ☐ epilepsy ☐ ear infection ☐ seizure ☐ asthma ☐ Other _____?

If so, please check and describe any special emergency treatment that may be required:

Please list any other conditions that might require emergency medical treatment: _____

_____ _____

*Signature of Parent/Guardian* *Date*

**Log of Attempts to Contact Parent/Guardian**

| Date | Time | Phone # Called | Answered? | | Person Answering Phone/Response |
|---|---|---|---|---|---|
| | | | Yes | No | |
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