



Falls Community Health—Hawthorne Site Sioux Falls School District

Student Consent Form

Student's Name: _____ Grade: _____

Birth Date: _____ Daytime Phone Number: _____

Falls Community Health (FCH) and the Sioux Falls School District have partnered to provide health care services for students at Hawthorne Elementary.

Services provided at Falls Community Health—Hawthorne Site (FCH/Hawthorne) will include:

- Physical exams and immunizations (*additional immunization consent will be required*)
- Routine lab tests and x-rays
- Care for acute illness and injury
- Assistance in care of chronic conditions—such as asthma or seizure disorder
- Follow-up as requested by family doctor
- Student health education

Students seen in the clinic must have a **signed consent** form on file at Hawthorne prior to receiving care. Please complete, sign, and return this consent form to the office of the school nurse. If your child receives services at FCH/Hawthorne, you will be contacted after each visit, either by phone and/or a visit summary, which will be sent to your home. You are encouraged to attend the visit with your child, if possible. A separate consent will be required for all immunization administration. The school nurse or staff from the FCH/Hawthorne can answer questions regarding the health center or health concerns you may have about your student. This consent form must be renewed each school year.

Information that will be shared with the Hawthorne school nurse upon seeing your child at the school-based clinic will include, but not be limited to:

- Completed school child physicals
- Summary of acute care visit
- Immunization records

See Reverse Side to Complete Consent

(Please initial one for each)

Consent for Services:

____ I **do** give permission for my child to receive services offered by the FCH/Hawthorne, or

____ I **do not** give permission for my child to receive services offered by FCH/Hawthorne

Provider Information:

____ My child does not have a physician, and I would like FCH/Hawthorne to be my child's provider, or

____ I request that my child's physician, _____, be sent a visit summary with each clinic visit.

Notification Authorization:

____ I must be notified prior to my child receiving any services at the FCH/Hawthorne, or

____ I authorize FCH/Hawthorne to provide services to my child when referred by the Hawthorne school nurse if I am unable to be contacted. I understand that these services will include an evaluation by a health care provider, and that any recommendations for treatment or follow-up will be communicated to me per phone contact or visit summary sent me.

Transportation Request:

____ I give permission for my child to be transported to the FCH site at 521 North Main Avenue upon giving my verbal consent prior to each transport, for health services unable to be rendered at the FCH/Hawthorne site, or

____ I do not give permission for my child to be transported to FCH without my presence.

I agree that I am responsible for payment of all services provided by FCH/Hawthorne either through Medicaid, insurance, or by self pay sliding fee based on income. I understand that this consent applies to all services (with the exception of immunization administration requiring separate consent) provided to my child at FCH—Hawthorne for the 2008-2009 school year.

(Parent/Guardian Signature)

(Date)