Falls Community Health
School-Based Health Clinic
Sioux Falls School District
Parent Consent Form

Student's Name: _____ Grade: _____

Birth Date: _____ Daytime Phone Number: _____

Falls Community Health (FCH) and the Sioux Falls School District (SFSD) have partnered to provide health care services for students at the School-Based Health Clinic (SBHC).

Services provided at Falls Community Health—School-Based Health Clinic will include:

Physical exams and immunizations.
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 **consent** from a parent/guardian prior to receiving care. Please complete, sign, and return this consent form to the SFSD school nurse. Consent for treatment must be obtained yearly.

Providing consent allows for information to be shared with between FCH and SFSD including, but not limited to:

Contact information (parent/guardian name, address, phone number).
Insurance (Medicaid) information.
Completed school child physicals.
Summary of acute care visit.
Immunization records.

If your child receives services at the SBHC, 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. Staff from FCH can answer questions regarding the health center or health concerns you may have about your child.

(Please initial one for each)

Consent for Services:

____ I **do** give permission for my child to receive services offered by FCH, including immunizations.

____ I **do** give permission for my child to receive scheduled dental examinations and routine treatment. I understand that I must be present for more complicated procedures like tooth removal or significant changes in the treatment plan.

Provider Information:

____ My child does not have a physician, and I would like FCH 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; or

____ I authorize FCH to provide services to my child when referred by the 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 to 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 SBHC.

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

Signature: _____ Date: _____
(Parent or Guardian)

FCH Employee Signature: _____ Date: _____