

Patient Information/Consent to Treat/Release of Information



Spartan Health Center



School Year: 2019/2020

Site: _____

Student: _____
Last Name First Name Middle Name

Birthdate: ____/____/____ Social Security Number: _____

Street Address: _____ City: _____ Zip Code: _____

Please check: Male Female

Please check all that apply:

- Black/African American White/Caucasian Asian American Indian/Alaska Native
- Native Hawaiian Other Pacific Islander Hispanic Refuse to Reply

Parent/Guardian Name: _____ Phone Number: _____

Relationship: _____

Health Problems: _____

Medications:

Name(s) and dosage of all medications currently being taken: _____

Does the student have any allergies: Yes No Medications: _____

Other: _____

Reaction: _____

Emergency Contact Information:

In case of emergency, please contact: _____

Relationship: _____

Phone Number: _____



Insurance Information:

If your child has insurance coverage through one of the insurances below, please provide information found on your child's card.



Other Medicaid

MMIS Number _____ Billing or ID# _____

Name of Private Insurance Company: _____

Policy Holder Name: _____ Employer: _____

ID#: _____ Group ID#: _____

Consent for Treatment and Release of Information

I _____ (Parent or Legal Guardian) hereby acknowledge that as the parent or legal guardian, I have given my consent to Health Partners of Western Ohio Health Center to administer such primary care as is appropriate and as indicated to _____ (Student's name), a minor child. I understand this care may include, but not be limited to sports/work physicals, minor injuries, immunizations, health screenings, routine sick visits, dental exams and dental procedures.

I also extend this consent to allow the release of medical information that Health Partners of Western Ohio considers appropriate, to any medical facility or provider who may require same to treat the student or for the purpose of collecting insurance. This consent includes releasing information regarding any medical or dental visits to the staff nurse at the location referring the child.

If medical information is released to a medical facility or provider, would you like to be notified? Yes No

Obtaining care through Health Partners of Western Ohio does not require changing your student's regular provider.

I have read and fully understand the statement above.

Parent or Legal Guardian

Date

This consent will be effective for the school year noted on the top of the form unless withdrawn in writing by the authorizing party.

