Southern Ohio Medical Center

very Good things are happening here

SOMC Eastern Family Practice Consent For Treatment

Eastern Local School and Southern Ohio Medical Center are offering a school based health program to Eastern students via the *SOMC Eastern Family Practice*. The goal of this program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the school based health program is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. Although we are happy to fill the need of a Primary Care Provider, you are not required to transfer your care to SOMC prior to or after being seen. The school district will still provide school nursing and emergency services as always whether you consent to participate in this program or not.

Patient/Student, First and Last Name _____ **Parent/Legal Guardian, First and Last Name** _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Area Code Phone Number _____ **Date of Birth (Month-Day-Year)** _____ **School & Grade Level** _____

Consent for Medical Care/Treatment:
I wish to have **ALL** applicable services / treatments available for the above referenced patient/student.
□ **YES** □ **NO** (If no, make selections of services/treatments you do consent to have available below)
□ Care and treatment for any injury or illness
□ Physical Examinations / well-child (i.e. sports, work, school)

Consent for Vaccinations:
I wish to have **ALL** vaccines available for the above referenced patient/student.
□ **YES** □ **NO** (If no, make selections of vaccines you do consent to have available below)
Required Vaccines* for School Attendance in Ohio Recommended Vaccines* **but not required by the Ohio Department of Health:**
□ DTaP / Tdap / Td Influenza (flu)
□ Meningococcal / Men B Human Papilloma Virus (HPV)
□ Measles Mumps Rubella (MMR) Hepatitis A
□ Varicella Pneumococcal
□ Polio Hib (Haemophilus influenza type B vaccine)
□ Hepatitis B *Age appropriate, following the American Academy of Pediatrics vaccination schedule

By signing this consent, I am authorizing SOMC Eastern Family Practice to provide the services to my minor child outlined in this form and to bill me/my insurance for any services rendered to my child at SOMC Eastern Family Practice. I understand that this consent for treatment will remain in effect for the 2019/2020 school year unless revoked by the consenting parent or legal guardian. I understand that I may make changes at any time to this consent or revoke it entirely by making a written request to SOMC Eastern Family Health Practice. I understand that even if I revoke my consent, as a parent of a minor child, my minor child may still consent to the treatment for which they are allowed to by law as described above. I have reviewed the SOMC Eastern Family Practice Overview of Services and understand the services available. It is my responsibility to tell SOMC Eastern Family Practice about changes in insurance coverage or changes to my child's health condition(s), immunization records, or medications. Additionally, I authorize SOMC Eastern Family Practice to request medical records/information from any health care provider or facility where my child has been seen and to send results of any treatment to my child's regular doctor/clinic. Furthermore, by signing below I am attesting that I am the parent/legal guardian of the above named child and understand that a new consent form must be signed by a legal guardian if this would change. Finally, I understand that if I am not this child's birth parent that I must provide documentation or an explanation of my ability to sign this consent on behalf of the minor child and have attached such documentation to this consent.

Parent/Legal Guardian *Printed* Name _____ **Parent/Legal Guardian *Signature*** _____ **Date/Time** _____
(If student is less than 18)

Student *Printed* Name (if student is 18+) _____ **Student *Signature*** _____ **Date/Time** _____