THE HEALTH & WELLNESS CENTER
AT CENTENNIAL HIGH SCHOOL

HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
2017-2018 - CONSENT TO MEDICAL TREATMENT

Instructions: Initial all statements, fill in information as requested and sign at the bottom

_____ I understand that medical services at the Health and Wellness Center at Centennial High School (the "Center") are provided by Rocky Mountain Youth Clinics (RMYC). I give permission for the Center to provide any of the physical health and mental health care services listed below to my student during his/her enrollment in the Center, when advised or recommended by the Center staff:

- Student health electronic questionnaire, (including medical & mental health questions)
- Well child check / sports physical
- Routine lab tests
- Treatment of minor illness and injury
- Management of chronic illness
- Referrals to community agencies for other necessary care

_____ I understand that the Center does NOT offer certain services, including but not limited to, the following:

- Hospitalization
- Emergency Care (except as required by law)
- Pharmacy services
- Restorative dental care
- Sutures / Casting
- Treatment of complex medical or psychiatric conditions
- X-Rays
- Dental fillings or extractions

_____ I have read above and understand the services offered by the Health and Wellness Center at Centennial High School and am requesting said services be provided to my student.

_____ I understand that the Center may serve as my student-patients primary care physician (PCP) and/or may collaborate with a PCP of my choosing and with my consent to release information.

_____ I understand that the Center maintains electronic medical records. I authorize electronic downloading of eligibility and medication history information.

_____ I understand that the Center staff will attempt to notify me about my student's encounter with the medical professional as deemed appropriate by the provider. I understand, that by law, in some instances students can access care independently and confidentially.

_____ I understand that this consent includes consent for referral of care and, if needed, to summon emergency services (911), emergency transportation to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the Center's staff. Expenses related to ambulance or other emergency referral will be my responsibility. Nothing in this authorization shall be deemed to modify or limit the responsibility and authority of the Center or Poudre School District to deal with emergency medical situations as is appropriate.

CONTINUED – SEE NEXT PAGE.

_____ I will attempt to make myself available for communication regarding my student's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the Center staff of any change in my student's guardianship.

_____ I consent for the Center staff to access my student's immunization and other school related records that may assist the staff in helping my child.

_____ I have received/read the Center and RMYC's Notice of Privacy Practices for Protected Health Information.

_____ I understand that all information in my student's medical record is confidential and will not be released to any unauthorized person or agency without written consent. This practice conforms to Colorado law.

_____ I authorize the Center to share or disclose all or any portion of my child's medical record to any entity pertinent to his/her healthcare, including but not limited to RMYC, the Center staff, the student's primary care provider, and the home school (insert school name): _____ health technician, nurse, counseling staff, coaching or administrative staff of student's. ***If there are specific roles I do NOT want information shared on the list above, I have crossed them off.***

_____ I understand that the Center may share or be required to share my student's health care information with certain persons or agencies for purposed treatment, health care operations, billing and payment or as otherwise required by law, without having to ask my permission or needing a signed authorization.

_____ I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for health services I receive at this school based health center and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients and this data does not specifically identify any individual patient.

_____ I understand the Center is open limited hours (generally during school hours/days Monday – Thursday) and is closed, for example at night, on weekends and for school holidays. During clinic closures I may call RMYC Thornton office at 1-303-450-3690 to reach the on-call provider or nurse line. If experiencing an emergency, I will take my student to the nearest emergency room or call 911 immediately.

_____ I understand that the Center needs to cover its expenses. I will provide my insurance information and I give permission for the Center/RMYC to bill my student's applicable health insurer for services received. If I do not have insurance, I agree to discuss my family's eligibility for available public insurance programs or sliding fee scale options with the Center.

_____ I understand that this consent form remains valid for the length of one year from the date of consent indicated below.

_____ I understand I may withdraw this consent at any time by providing written notice to the Center's Health and Wellness Coordinator at the Health and Wellness Center at Centennial High School, 330 East Laurel Street, Fort Collins, CO 80524. This is called revocation. I understand that once written notice is received, the Center will stop sharing information from that point on, but that revocation does not apply to any information the Center has already released.

Agreement: By signing below I acknowledge that I have read and understand the above provisions and certify that I am legally authorized to provide this consent for services.

I am enrolling this student in the Health and Wellness Center at Centennial High School **Yes** **No**

_____ _____

Printed Name of Student **Date**

_____ _____

Printed Name of Parent/Guardian (or Student if 18+) ***Signature of Parent/Guardian (or Student if 18+)***