VINE SCHOOL HEALTH CENTER *PERMISSION FOR SERVICE/TREATMENT*

Child's Name: ____ **Birth Date:**_______________ **Child's Gender:** _______________

Child's Social Security Number: ____________________________________ Grade:__________ School: ______________________

Child's Address: ____ Zip:_______ Child's Race: _____________

Parent/Guardian's Printed Name: ____ Parent/Guardian's Birth Date: ______________

Parent/Guardian's Cell Phone: ___________________________ Parent/Guardian's Home Phone: ______________________________

Parent/Guardian's Email: ____________________________ Parent/Guardian's Employer & Phone:______________________________

What pharmacy do you use: ____ **Location:** ___________________________

Does this student have health insurance? ____No ____Yes Type: ____

Does this student have a primary care provider, clinic, or doctor? ____No ____Yes, who? ___________________________________

Has this student been seen in the emergency room within the past year? ____No ____Yes, for what? ___________________________

Does this student:
Have any health problems? ____No ____Yes, explain: ____
Take any medications? ____No ____Yes, list: ____
Have any allergies? (To food, medication, etc.) ____No ____Yes, list: ____
Have any mental health problems? ____No ____Yes, explain: ____
Have any educational problems? ____No ____Yes, explain: ____
Is this student on the free or reduced lunch program at their school? ____No ____Yes

Did this student use our services last school year? ____No ____Yes ____Don't Know
If Yes, the health services provided were: ____ Excellent ____Satisfactory ___Unsatisfactory
Do you have any suggestions for the Health Center's services? ____

*****<u>In order for this student to have services at Vine School Health Center, please sign all five signature lines below:</u>**
The Vine School Health Center is a collaborative effort between Knox County Schools and the University of Tennessee, College of Nursing and is located in the Vine Middle Magnet School and with satellite clinics in other schools. I understand that these services, performed when requested by parents or after parents have been contacted by clinic staff, will be provided by a staff of nurses, nurse practitioners, social workers, educational psychologists, student nurse practitioners, and student nurses, and physicians, and include but are not limited to: well child exams, immunizations, health education, acute illness care, general first aid, mental health counseling, case management, educational testing/assessments, nutritional assessments, and sport physicals. By signing this form, I am giving my permission for this student to receive services from the Vine School Health Center. The Center will bill for health services rendered.
*****Parent/Guardian's Signature**: ____ **Date:** _______________

I have received the copy of the Health Center's Notice of Privacy Practices Agreement.
*****Parent/Guardian's Signature**____**Date:** ________________

Other consulting partners of the Vine School Health Center include Pediatric Consultants/University of Tennessee physicians and East Tennessee Children's Hospital (ETCH If your child is evaluated in the ETCH emergency room, we can provide follow-up care if needed. I give ETCH permission to release health information to the Vine School Health Center regarding my child's evaluation and treatment in the emergency room.
*****Parent/Guardian's Signature**____ **Date:** ________________

I authorize Vine School Health Center and the Knox County School System to discuss referrals and appointment information.
*****Parent/Guardian's Signature**____**Date:** ________________

There may be many other persons in your child's life who assist with care, such as grandparents, aunts, uncles, step-parents, neighbors, and friends. If you have someone like this who helps you that we can call or provide information to about your child please list those persons below. I authorize Vine School Health Center to disclose the personal health information of my child consisting of: appointment information, diagnosis information, and/or medical/medication information & instructions to *(List names of designated persons and contact numbers)*:
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*****Parent/Guardian's Signature**____**Date:** ________________