Northeast Ohio Neighborhood Health Services, Inc.
Shaw High School Wellness Center

PARENT/GUARDIAN CONSENT FORM

Please read carefully and complete the following consent statement authorizing your son or daughter or ward to receive services at the Shaw High School Wellness Center.

Please Print

Student's Name:	Birth date:
Address:	Student's Social Security #:
City: Zip code:	Student's Gender: ☐ Male ☐ Female

I give consent for my son/daughter/ward named above to receive the following services at the Shaw High School Wellness Center, operated by Northeast Ohio Neighborhood Health Services, Inc. (NEON)

- Comprehensive health history
- Physical examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (TB testing, eye, dental, hypertension, etc.)
- Assistance with chronic (ongoing) illnesses
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Comprehensive social services
- Dental Services (comprehensive oral exam, prophylaxis, sealants, and fluoride supplements)

Please cross out any of the above services that you do not wish to be provided for your child.

I hereby authorize a physician and other professional clinic staff to provide the necessary and/or advisable treatment for my son/daughter/ward.

Students presenting to the Wellness Center in need of services not provided at the clinic will be referred to other area health care providers. I authorize the East Cleveland School District to release my son/daughter/ward's school health records to the Wellness Center.

I understand that these services are confidential. I understand that medical records of patients in the Wellness Center are confidential and the property of NEON. The records will not be released to any person or entity without the written consent of the parent/guardian, except as required by law (i.e., communicable diseases, etc.). I understand that certain components or data will be released at times without release of any student's name.

I release the East Cleveland City School District, its members, officers, employees, agents and representatives from any and all claims, suits, actions, liabilities, legal costs and attorney's fees arising out of the operation of the school-based Wellness Center.

Please Print

Parent/Guardian:	Date:
Address:	Home Phone:
City: Zip code:	Work Phone:

I certify that I have read this form and understand its contents, and agree to the release of liability provisions. (If the student is age 18 or older, no parent/guardian signature is required.)

Signature of Parent/Guardian:_____ Date Signed: _____

Relationship to Student:_____

You must complete the <u>FINANCIAL RESPONSIBILITY</u> section on the back of this form.

FINANCIAL RESPONSIBILITY

Student's Name:_____

As parent/guardian of the above-named student, I assume responsibility for all costs, charges, and expenses for services rendered by the providers of the Shaw High School Wellness Center and/or Northeast Ohio Neighborhood Health Services, Inc.

I understand that students who have coverage under Medicaid or any of the Medicaid HMOs (CareSource, Molina, and Buckeye, etc.) will be fully covered for services at Shaw High School Wellness Center.

I understand that students who have coverage under any other insurance plan (Healthspan, Medical Mutual, or any other insurances) may (or may not) have their services covered at Shaw High School Wellness Center. I understand that any expenses not paid for by that insurance company will become the responsibility of the undersigned.

I understand that students who have no insurance coverage will have an opportunity to make financial arrangements by applying for a sliding scale to reduce any charges.

I understand that every effort will be made to make any charges as reasonable as possible.

Date: _____ Signature: _____

Relationship to Student: _____

Indicate which type of insurance the student has by checking below:

- ☐ Medicaid
- ☐ CareSource
- ☐ Molina
- ☐ Buckeye
- ☐ Paramount
- ☐ United Health Care
- ☐ Health Span
- ☐ Other Insurance (name):_____
- ☐ No insurance

THE FOLLOWING INFORMATION MUST BE COMPLETED OR YOU WILL BE BILLED FOR THE SERVICES:

Please Print

Name of Insurance Plan:	
Cardholder Name:	
Patient Identification Number:	Group Number:
Coverage Effective Date:	

PLEASE RETURN THIS COMPLETED FORM TO THE SHAW WELLNESS CENTER (Room 500)