

**THE KANSAS CITY MISSOURI SCHOOL DISTRICT
SCHOOL BASED HEALTH CLINIC
PARENT PERMISSION FORM**

The school based health clinic is available for your child's health needs. This is a collaborative partnership between the Kansas City Missouri School District and Community Medical agencies.

Before a student may receive any medical nursing and /or social services offered by the Health Clinic, a signed consent form must be on file every school year. Medicaid school services (emergency first aid, etc.) are available for every student. MC+ for kids information must be provided because provider services will be billed to Medicaid as indicated. **Students should bring their Medicaid or MC+ card for each clinic visit.**

_____ **Clinic is open from** _____ **to** _____.

Services vary at each clinic but can include:

1. Health assessments/physicals for sports, cheerleading, or routine; human development, health risk screening, vision and hearing screening, immunizations, PPD, and GYN exams, EPSDT screenings.
2. Laboratory screenings which will include routine blood check, urine, strep throat, PAP smears, and STDs.
3. Treatments for minor injuries, minor infections, asthma attacks, administering prescriptions and over the counter medications.
4. Counseling in nutrition, relationship, sexuality, drugs, alcohol, and tobacco addiction.
5. School Nursing Services include First Aid and Emergency care, identify and manage students with chronic conditions, monitor and administering medication, maintain immunization records and promote health education.

Consent Form

Student Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Student Number: _____ School Name: _____

Parent or Guardian Name: _____

Check One: No insurance___ Private insurance___ Medicaid or MC+___

Primary Medicaid MC+ Provider: _____

Physician Name and Phone Number: _____

Medicaid insurance Number: _____

My child, _____, has my permission to receive services offered by Kansas City, Missouri School District's School Based Clinics. I understand and consent to my child's medical records being shared between the Kansas City, Missouri School District, and it's contracted agent.

I DO NOT want my child, _____, to receive the following services through the Health Clinic _____.

Parent or Guardian Signature: _____ Date: _____

Clinic Received Date and initials: _____