

CONSENT FOR SCHOOL-BASED HEALTH CENTER

__Yes- I consent for my minor child to receive health care services by Baptist Health in the school-based health center as determined by the school-based health center's staff. I further consent for my child to receive medical care through telehealth and/ or remote patient monitoring, and to the interpretation of diagnostic studies from an off-site location using telehealth technologies.

- This consent will remain in effect until the end of the existing school year in which this consent was signed. Or until I revoke this consent in writing and provide the revocation to the staff of Baptist Health.
- I affirm that I have the right to consent as the parent or legal guardian of the minor child as listed below. I understand that it is my responsibility to notify Baptist Health about changes in my legal guardianship.
- I understand that Baptist Health may notify me if my minor child received care in the school –based health center, except in the event my
 minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky
 Revised Statue 214.185.
- I authorize Baptist Health and each of their staff to communicate with my minor child's healthcare providers about healthcare services rendered by Baptist Health at the school-based health center.
- I authorize Baptist Health to bill my health insurance provider for healthcare services rendered at the school-based health center.

Student's Name	Date of	Birth	SS#	
School		Grade		
Home Address	City	State	Zip	
Name of Parents/Guardians	Parent	Parents/Guardians Phone Number		
Policy Holder's Name	Policy Holder's Da	te of Birth		
Policy Holder's Address	City	State	Zip	
Policy Holder's SS#	Policy Holder's	Policy Holder's Employer		
Name of Health Insurance	Policy #	Group _		
Student's Allergies (including medication a	llergies)			
Pharmacy of Choice	Phar	Pharmacy Phone#		
Emergency Contact	Relationship to Stu	dent	Phone#	
Name of Student's Doctor/Office		Phone#		
(The school-based health center will need	a copy of your insurance car	d, front and back)		
Confidentiality: The information in my min not be released to any unauthorized personal be necessary for staff of the school-based professional about treatment related to not treatment provided to my minor child at the doctor.	on or agency without my au health center to confer amony my minor child. I understand	thorization. Howeve ong themselves and I that as a courtesy,	er, I understand that it may the school's health medical records of any	
Signature of Parent or Legal Guardian	Legal Guardian		Date	