METRO CARE CONNECTION
Cedar Rapids Community School District
School-Based Health Centers & Services

Metro Care Connection Health Care Consent Form

A student must have a consent form signed before being treated at a Cedar Rapids Community School District Metro Care Connection health center**. Please complete the following information, sign the form where indicated and return it to the school health center. Thank you

General Information

Student Name__________________________ School__________ Grade__________

Student aliases or other names__________________ Date of Birth______________ Sex________

Ethnicity______________ Student race______________ Email address____________________

Language spoken______________ Written language______________ Preferred Language__________

Address______________________________________ Home Phone ________________

City ____________________ St.________ Zip________ Cell Phone________________

Parent/Guardian Name________________________ (**Please Print**) Emergency Phone Number __________

Are you the legal guardian? Yes ☐ No ☐

Student Health History

Does your child have any allergies to **medications**? _____ Yes _____No

Please list **all of** your child's allergies:________________________________

Please list any health conditions your child has (such as asthma, diabetes, seizures, ADHD, depression):

____

Please list any medications/treatments your child is currently receiving:__________________

Please list any surgeries your child has had:______________________________

Consent to Receive Services

I give my consent for my child to receive health services from the Metro Care Connection health center including over the counter medications. If I have requested that my child receive a routine or sports physical, I understand that an age-appropriate complete full-body exam will be offered as part of our comprehensive services. I understand that all information about my child is confidential and will be treated in accordance with acceptable medical practice and the federal and state laws regarding privacy.**

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian)

While I consent to having services provided to my child, I **DO NOT** want him/her to receive the services noted:

____

Physician

Do you have a physician?____ Yes ____ No If yes, what is the physician's name____________________

I authorize Metro Care Connection Health Center staff to contact my child's physician/health care provider to share information concerning my child's health by fax, phone, etc.

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian) **5/19**

Please see other side for additional needed information

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Insurance Info

Insurance Status

My child has (please check all that apply): ___ no health insurance Student Social Security Number ________________

___HAWK-I ___ Medicaid/Title 19 **(please provide Medicaid State ID policy number)**________________________

___ private insurance: Are "well visits" covered? __ Yes __ No

Name of insurance/Managed Care company________________________________

Please bring a copy of the student's insurance card to the child's appointment. Providing Medicaid/Insurance information ensures our clinics can continue to provide these valuable health services.

Release of Information and Acknowledgement of Privacy

*Iowa Medicaid allows for Local Education Agencies (CRCSD's Metro Care Connection) to request reimbursement for Primary and Preventive services provided by Metro Care Connection. **I authorize** MCC staff to disclose personally identifiable information belonging to my child to the Iowa Department of Human Services and its contractors, ("Medicaid") for purposes of determining my child's eligibility for Medicaid, and if my child is determined to be eligible for Medicaid, for purposes of billing Medicaid for Medicaid-covered health services provided to my child. Should my child have other insurance in addition to Medicaid, I understand that Medicaid may forward claims to the other insurance for processing. This process is in compliance with all federal regulations and would not impact the existing benefits or impact access to any services. I understand that a photocopy or other reproduction of this signed and completed form shall have the same force and effect as the original, unless otherwise prohibited by law.

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian)

Electronic Health Record Notice

- I understand that my child's Metro Care Connection health visits will be a part of the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System. Because my child has a medical record within the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System I understand that my child's record may be viewed by MercyCare Service Corporation health care employees and in some situations could be viewed by other healthcare providers outside of Mercy through the EPIC Care Everywhere connection.

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian)

Privacy Notices

- I acknowledge that I have had opportunity to read/receive Metro Care Connection's FERPA Notice of Right's and HIPAA Notice of Privacy Practices. A copy of the full disclosure can be obtained in one of our MCC clinics or accessed on the MCC website http://mcc.cr.k12.ia.us .

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian)

Transportation

I give my consent for my child to be transported for health care services if I am unavailable. (Regulation 901.7)

X **Date**

Parent/Guardian Signature (Must be signed by Legal Guardian)

**Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), 20 USC § 1232g, 34 CFR §99.31, the school corporation, prior to disclosing personally identifiable information from a student's records to the Iowa Medicaid agency, must obtain "written consent from the student's parents specifying records to be released, the reasons for such release, and to whom, and with a copy of the records to be released to the student's parents and the student if desired by the parents." This signed authorization is valid for a period of one (1) year from the date signed. This form must be maintained and made available for audit purposes.*

*** Iowa codes 139A.35 and 141A.7 provide that a minor may consent for diagnosis of pregnancy/sexually transmitted disease testing and the treatment of any STD and that the consent of a parent or guardian is not necessary for these services.* **5/19**

Please see other side for additional required information