# Consent form

## STUDENT INFORMATION:

First Name:_____ MI: _____ Last Name: _____

Mailing Address: _____

City:_____State: _____Zip Code: _____

Date of Birth: ____/____/____ Social Security Number: _____/_____/_____

Gender: Male ☐ Female ☐ School: _____Grade Level: _____

Name(s) of Parent(s)/Guardian(s): _____

Telephone Home: _____ Work:_____ Cell: _____

*If we are unable to reach the Parent or Guardian, please list an emergency contact.*

Emergency Contact: _____ Telephone: _____

Relationship to Student: _____

## MEDICAL INFORMATION:

Who is the student's regular physician? _____

Is the student allergic to any medications? Yes: ☐ No: ☐

If yes, please list: _____

Is the student taking any prescribed medications on a regular basis? Yes: ☐ No: ☐

If yes, please list medication and dosage:

Is there any other medical information regarding the student that should be noted?

Preferred Pharmacy: _____

➥ *Please complete the reverse side of this form as well.*

## INSURANCE INFORMATION:

Name of Insured: _____ Employer: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Insured's Social Security Number: _____ - _____ - _____ Insured's Date of Birth: _____/_____/_____

Policy Number: _____

Do you have a Medical Card for the student issued by the Department of Health and Human Services?

Yes: ☐ No: ☐ If yes, please write down the card number: _____

Please, select coverage plan: ☐ Medicaid ☐ The Health Plan ☐ Aetna ☐ UNICARE ☐ Other _____

Is the student covered under WVCHIPS? Yes: ☐ No: ☐

**I, the Parent or Guardian of the student listed on this form, do hereby consent for (Him/Her) to receive treatment through Brandon School-Based Health Services for the following services**:**

☐ **Full Services:**

Full services includes:

- ✔ Medical Provider Appointments
- ✔ Individual Therapy
- ✔ Tele-Psychiatry

☐ **Free Services:**

Free services include (✔check all approved):

- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Claritin
- ☐ Benadryl
- ☐ Cough syrup
- ☐ Antacids
- ☐ Cough drops
- ☐ First aid creams

**Well Child Check** (annual physical) can be completed in the school-based clinic.
**Would you like a Well Child Check completed at the school-based clinic?** Yes: ☐ No: ☐

Date of last Well Child Check (if known): _____/_____/_____

***All attempts will be made to contact parent/guardian before full and free medical services provided.*

**I, the Parent or Guardian of the student listed on this form, furthermore, do understand that I am responsible for all fees incurred for services provided to the student and I understand the Notice of Privacy Practices for the Center.**

Parent's or Guardian's Signature:

_____

Date: _____/_____/_____

BRANDON SCHOOL-BASED HEALTH SERVICES
BARBOUR COMMUNITY HEALTH

99 Horseshoe Drive | Philippi, WV 26416
(304) 457-4000

www.barbourhealth.org