CONSENT FOR SHC (School Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at the SHC. I understand this consent will be good until my child leaves / graduates school or until I provide the School Health Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving SHC, school nurse and our child's regular doctor permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding this information will continue to be treated in a confidential manner. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternate contact.

With my consent, SHC and its providers have the ability to view my external prescription history via SureSripts for purpose of my care and treatment. I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

______________________________________ Relationship ______________________________

Printed Name of Parent/Legal Guardian

______________________________________ Date: ______________________________

Signature of Parent/Legal Guardian

______________________________________ Date: ______________________________

Signature of Student

______________________________________ Date: ______________________________

Signature of School Health Witness/Verify

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Mississippi state law prohibits health centers in schools from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products contact the Office of Public Health.