



# Health Partners of Western Ohio - Spartan Health Center

## Patient Information/Consent to Treatment & Release of Information

Student/Patient Information			
Student/Patient Name:			
Date of Birth:	Sex (please check one): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unspecified	Social Security #:	
Home Address:		City:	
State:	Zip code:	Phone Number:	
School Name:			
Ethnicity (please circle): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> African America <input type="checkbox"/> Hispano/Latino <input type="checkbox"/> Decline <input type="checkbox"/> Other:			
Name of Primary Care Provider (PCP):			
Legal Guardian Information			
Guardian's Name:			
Date of Birth:		Social Security #:	
Home Phone:		Cell Phone:	
Student/Patient Insurance Information			
Student/Patient has insurance (please check) <input type="checkbox"/> Yes or <input type="checkbox"/> No			
Name of Insurance Company:		MMIS Number:	
ID Number:		Group Number:	
Emergency Contact Information			
Name:	Relationship:	Phone Number:	
Student/Patient Current Medications (vitamins, inhalers, prescriptions, other)			
Name of Medication	Dose	Amount Taken	Times per Day
Preferred Pharmacy			
Address:		Phone Number:	
Student/Patient Allergies			
<input type="checkbox"/> YES - Please list below <input type="checkbox"/> NO Known Allergies			
Medication:		Food:	
Insect/Animal:		Seasonal:	
Student/Patient Hospital/Surgery History			
Student Name:		Student Date of Birth:	
Family History list who has health problem next to the problem (ex: mom, dad, sibling, or grandparents)			



Anemia:	High Blood Pressure:
Diabetes:	Asthma:
Heart Disease:	Stroke:
Sickle Cell:	Cancer:
Mental Health:	Other:

**Patient/Student Health History (please check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Cancer/Leukemia   | <input type="checkbox"/> Migraines        |
| <input type="checkbox"/> Mental Health (ex: ADHD, depression, anxiety) | <input type="checkbox"/> Premature Birth   | <input type="checkbox"/> Sickle Cell      |
| <input type="checkbox"/> Bladder/Urinary Problems                      | <input type="checkbox"/> Blood Disorders   | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Kidney/Renal Disease                          | <input type="checkbox"/> Spine Disorders   | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Bowel Issues/Constipation                     | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hearing Aid      |
| <input type="checkbox"/> Other: _____                                  |  |   |

**Consent for Treatment and Release of Information**

I \_\_\_\_\_ (parent or legal guardian) hereby acknowledge that as a parent or legal guardian, I have given my consent to Health Partners of Western Ohio Health Center to administer such primary care as is appropriate and as indicated to \_\_\_\_\_ (student's name), a minor child. I understand this care may include, but not be limited to sports/work physicals, minor injuries, immunizations, health screenings, preventative care, routine sick visits, behavioral health services, dental exams and dental procedures.

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when student/patient is located at a different site than the provider. I hereby consent to the provision of health care services via telemedicine when the provider is off site. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.

I also extend this consent to allow the release of health information that Health Partners of Western Ohio considers appropriate, to any medial facility or provider who may require same to treat the student or for the purpose of collecting insurance. This consent includes releasing information regarding any health visits to the staff nurse at the location referring the child.

If health information is released to a medical facility or provider, would you like to be notified?  Yes or  No

**Obtaining care through Health Partners of Western Ohio does not require changing your student's regular provider.**

If you have health insurance, your health insurance will be billed for services. If you do not have health insurance, you will be responsible for the bill at the appropriate discounted fee. You might qualify for a discounted fee. No student/patient will be denied care due to inability to pay for services. We can help you if you need assistance applying for insurance. You can stop into our center or give us a call.

I understand this consent will remain valid as long as my child remains a student within Lima City Public Schools unless revoked by me. I may revoke this consent for treatment at any time by requesting in writing that the school based health services remove my child from services. If my child is not enrolled in Lima City Public School, this consent is valid for one calendar year from the date signed.

**I have read and fully understand the statement above.**

\_\_\_\_\_  
Parent or Legal Guardian (Signature)

\_\_\_\_\_  
Date

8/2022

