CONSENT FOR SCHOOL-BASED HEALTHCARE SERVICES

Orange County Public Schools
445 W. Amelia Street, Orlando FL 32801 407-317-3200
"The Orange County School Board is an equal opportunity agency"

Services provided by Healthcare Providers of Florida, Inc.

Minor Child Consent Form

Please read carefully and complete the following statement authorizing the provision of healthcare services from Healthcare Providers of Florida, Inc. to your minor child. Healthcare Providers of Florida, Inc. is a third party entity not owned or operated by Orange County Public Schools. Your child will be treated by an Advanced Practice Registered Nurse (APRN) from Healthcare Providers of Florida, Inc.

I hereby consent for my child _____ (first and last name) Date of Birth: _____

To receive the following services provided by Healthcare Providers of Florida, Inc.:

1. Comprehensive health history,
2. Physical examination for school entry and sports participation, including inguinal hernia exam for males,
3. Examination, diagnosis, testing and treatment for minor illnesses and injuries,
4. Screening for selected health problems,
5. Management of chronic illness,
6. Periodic screening for wellness, anticipatory guidance, preventive testing and treatment as outlined by Medicaid,
7. Referral to specialists,
8. Preventive health education,
9. Counseling, and/or
10. Administration of medication

Please list by number any services you **DO NOT** wish your child to receive: _____

I understand that the confidentiality of my child's medical records, as a patient receiving care, is required by law, and those records will not be released to any person or entity without prior permission. I hereby release Healthcare Providers of Florida, Inc. and Orange County Public Schools, along with their affiliates, directors, officers, employees, agents, successors and assigns, from any and all liability arising from or in any way connected to my child receiving these services. My signature below authorizes medical treatment, billing of insurance, if any, receipt of the notice of privacy rights as required by HIPAA, and confirms the accuracy of the Medical Information provided below.

Parent/Legal Guardian (print) _____

Phone (cell) _____ Phone (alternate) _____ Email_____

Address _____ City _____ Zip _____

School Attending _____

SIGNATURE _____ **DATE** _____

Medical Information

Medical Provider _____**Preferred Hospital** _____

Insurance: Yes __ No _ **Insurance Name**_____ **Type:** Private ___ Medicaid ____ Healthy Kids___

Medical History: Food/Drug Allergies _____ Current Medication(s) _____

Serious/Chronic Medical Conditions _____ Surgeries _____

Hospitalizations _____Other_____