Metro Care Connection
School Based Health Centers

Metro Care Connection Consent Form

Cedar Rapids Community School District

Student Name:	**Date of Birth:**
School:	**Grade:**
Home Address:	**Phone Number:**
Gender assigned at birth: ___ Male ___ Female	Gender identity: ___ M ___ F ___ NB
Preferred Language:	Do you identify as Hispanic? ___ Yes ___ No ___ Prefer not to say
Race: ___ American Indian/Alaskan Native ___ Asian ___ African American ___ Caucasian/White ___ Native American/Pacific Islander ___ Other: _____ te___ Prefer not to say	
Name of Primary Care Provider/Physician (PCP):	
Parent/Guardian Name:	
Home Phone:	Cell Phone:
Child/Teen has insurance: ___ Yes ___ No	Student Social Security #:
___ Medicaid ___ Hawk I ___ Private	Medicaid ID Number*:_____ (This is required for students with Medicaid)

Does your child have any allergies? _____ No _____Yes

If yes, please list <u>all of</u> your child's allergies <u>and reaction</u>:_____

_____

Please list <u>any and all health conditions</u> your child has (such as asthma, diabetes, seizures, ADHD, depression): _____

_____

_____

Please list all medications your child is currently taking (prescription, OTC, vitamin/supplements:)_____

_____

Please list all surgeries your child has had:_____

I give my consent for my child to receive services from a CRCSD Metro Care Connection nurse practitioner with or without the presence of a parent/guardian. The parent/guardian understands that he/she/they has the opportunity to ask and have any questions answered about the risks, benefits, and alternatives of the services by contacting Metro Care Connection at 319-558-2481. 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.**

Parent / Legal Guardian / Student* Printed Name: _____

Parent / Legal Guardian / Student* Signature: _____ **Date:** _____

PLEASE COMPLETE NEXT PAGE

Student Name: _____ **Date of birth:** _____

Services that I DO NOT consent for my child to receive: _____

_____

Additional Consents/Permissions:

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.

I authorize Metro Care Connection to request reimbursement for Primary and Preventive services provided by Metro Care Connection through Iowa Medicaid as allowed for Local Education Agencies (CRCSD's Metro Care Connection). By signing below, 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.

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.

I acknowledge that I have had the opportunity to read Metro Care Connection's HIPAA Notice of Privacy Practices. A copy of the full disclosure can be obtained in one of our MCC clinics and is available online at:
https://crschools.us/students-and-families/student-services/health-services/metro-care-connection/

I give my consent for my child to be transported for health care services, by a school staff member, if I am unavailable. Prior notification will be given to parent/guardian before transporting. (CRCSD Regulation 901.7)

***By my signature below I certify,* as the parent or legal guardian of the student named above, I understand the School-Based Health Center consent for treatment, including additional consents and permissions. THIS CONSENT FORM WILL REMAIN VALID WHILE THE STUDENT IS ENROLLED IN CRCSD OR UNTIL TERMINATED IN WRITING.**

Parent / Legal Guardian / Student* Printed Name: _____

Parent / Legal Guardian / Student* Signature: _____ **Date:** _____

Students age 18 or older, or legally emancipated, may independently sign for their own consent.

***** 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.***