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 ____Grade ____________________________

Primary Care 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______________________________________

SIGNATURE ____**DATE** _____________