St. George Medical Clinic, Inc.
School Based Health Center
ENROLLMENT AND CONSENT FORM
Tucker County Schools

STUDENT INFORMATION

Student Name: _____Student SS#: _____
Address: _____ Email Address: _____
City/State/Zip: _____
Cell: _____Grade: _____ Birth Date: _____

Gender: *Female/Male* Race: *White, Black, Hispanic, or Other*: _____

PARENT/GUARDIAN INFORMATION

Father: _____Phone (H): _____ (C) _____(W) _____
Mother: _____ Phone (H): _____ (C) _____(W) _____
Guardian: _____Phone (H): _____ (C) _____ (W) _____
Alternate Contact: _____ Phone (H): _____ (C) _____(W) _____

CONSENT FOR SGMC (St. George Medical Clinic, Inc.) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at any Tucker County School location from St. George Medical Clinic, Inc. I understand that this consent form will be good until my child leaves/graduates school or until I provide SGMC staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form, you are giving SGMC, Tucker County School Nurse, and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. SGMC may release information regarding treatment to third party payers for billing purposes.

Confidentiality between the student, parents/guardians, 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 that if guardianship changes, a new consent form 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 alternative contact.

_____ _____

Signature of Parent/Legal Guardian Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Please note that there is an attached copy of HIPAA to this consent form for the parent/guardian of the student receiving medical or mental health counseling services from SGMC. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services.

I certify that a copy of HIPAA was provided with the St. George Medical Clinic consent form, to the parent/guardian of _____.
Student Name

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of SGMC staff Date