EDWARD M. KENNEDY COMMUNITY HEALTH CENTER

PARENT/GUARDIAN CONSENT

I give consent for my child to receive health services at any of the school-based health centers offered by Edward M. Kennedy Community Health Center (Kennedy Community Health).

I authorize a health practitioner to provide physical, dental and behavioral health services for my child in person or through a secure telehealth platform. I give permission for necessary medical tests, evaluations, and management of my child's health care. I also consent to the exchange of health information between the school health center providers, school nurse, school adjustment counselor, and any other medical professionals that may be needed. I understand that my child's health record will be securely maintained by Kennedy Community Health as a confidential medical record; it is not a school record. I also understand that confidentiality will be observed between the staff and any child using the school-based health center.

The school-based health centers take part in the Massachusetts Immunization Information System (MIIS). MIIS is a confidential statewide system to keep track of immunization records for children and adults. To limit who can see your child's information, you need to fill out the 'Objection or Withdrawal of Objection to Data Sharing" form, which you can get from your healthcare provider.

I further authorize Kennedy Health Center to release information regarding treatment to third party payers or others for billing purposes and for any reason that may be required to comply with statues, laws or regulations in accordance with accepted medical practice. I have read and completed this consent form and understand that this consent form will be in effect as long as my child is enrolled at a school affiliated with Kennedy Community Health unless I notify the school health center in writing.

Student first name _____ Student last name _____

Date of birth ____/____/____ Gender _____ Pronouns _____

Address _____ City _____ State _____ Zip _____

Preferred Telephone _____ Alternate Telephone _____

May we text? ☐ Yes ☐ No

Email _____

Ethnicity: ☐ Hispanic ☐ Non-hispanic

Preferred Language _____

Race (you can specify more than one):

- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Unknown/Not Specified
- ☐ Other (specify)
- ☐ Prefer not to answer

Parent/Guardian Name _____ Relation to Student _____

***Signature of Parent/Guardian** _____ ***Date** _____

EDWARD M. KENNEDY COMMUNITY HEALTH CENTER

STUDENT MEDICAL INFORMATION

Please note the school-based health centers do not collect co-pays and provide care regardless of the ability to pay.

Complete either A, B, or C to the best of your ability.

A: Private Insurance Company:_____

Policy#:_____Group#:_____

B: Mass Health/Medicaid: Medicaid ID#_____

C: No Insurance ☐ Would you like assistance in insurance enrollment? Yes ☐ No ☐

Complete either A or B to the best of your ability.

A: _____ _____
Student's Primary Care Provider (PCP) PCP's Phone number

B: No PCP ☐

Would you like assistance in establishing a PCP? Yes ☐ No ☐

_____
List any medications student is currently taking

_____
List any known medical conditions

_____
List any allergies

_____
List any family medical history (mental health concerns, heart conditions, asthma, allergies, etc.)

For questions regarding the school-based health centers, call (508) 595-1102