2015 / 2016
WELLNESS HUBS

INTEGRATING HEALTH AND EDUCATION TO EMPOWER STUDENTS TO BE HEALTHY AND READY TO LEARN

Consent for Services

I give permission for Umatilla County Wellness Hub nurse to provide medical services to the above-named student. I understand the following types of services are provided: physical health assessment, and treatment of illness and injury, vision / dental screenings, routine lab tests, immunizations, health education, over the counter medications, and referral for health care services not provided by the Wellness Hub.

I also authorize and give permission to the Wellness Hub to contact the above-named student's personal care physician to share medical information regarding ongoing medical needs.

I understand that the Wellness Hub is a collaboration between Wellness Hub staff, Umatilla School District (USD), InterMountain Education Service District (IMESD) and Umatilla County Public Health and that information regarding student well-being may be shared between Wellness Hub and USD staff for the safety, health, and overall academic success of the above-named student.

I authorize the release of any medical and protected health information necessary to process this claim and authorize payment of medical benefits for services by the Wellness Hub. Insurance will be billed for services provided at the Wellness Hub. Any services provided outside of the Wellness Hub (such as pharmacy, radiology, or labs) are the responsibility of the parent and/or guardian.

Wellness Hubs are required by law to maintain the privacy of your health information. A copy of the Notice of Privacy Practices is available at http://www.umatillacounty.net/health/SBHC/PrivacyPracticesEnglish.pdf I understand the Wellness Hub has the right to change this Notice at any time. A current copy is available upon request by contacting the Wellness Hub.

I have read the above information and have had the opportunity to ask questions. I understand I may revoke this consent at any time*.

Signature: _____ **Relationship:** _____ **Date:** _____

*We support and encourage parental involvement in decisions about a child's health care. Oregon State Law requires the signature of a parent or guardian for medical treatment for students less than 15 years of age with the exception of family planning information and sexually transmitted infections. ORS 109.610, ORS 109.640.

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Today's Date:_____

Student's Last Name: _____ **First Name**: _____ **MI**: ___

Grade Level: _____ **Date of Birth**: _____ **Gender**: □ Male □ Female

Ethnicity: □ Hispanic □ Non-Hispanic **Race**: □ White □ Pacific Islander □ Native American □ Black □ Asian □ Other

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Parent / Emergency Contact Information

Name: _____ **Relationship**: _____

Phone Number: _____, _____, _____

Name: _____ **Relationship**: _____

Phone Number: _____, _____, _____

Insurance Information

Oregon Health Plan / EOCCO

Policy/ID Number: _____

Private Insurance Coverage

Name of Insurance Company:_____ **Effective Date:** _____

Company/Claim Address: _____

Insurance Company Phone Number: _____

Policy / ID Number: _____ **Group Number:** _____

Name of Insured Person: _____ **Date of Birth:**_____

Relationship to Student: _____

Does the student have secondary insurance? □ Yes □ No

Health Information

Allergies to Medications? □ Yes □ No Which ones? _____

Chronic Medical Conditions _____

Current Medications: _____

Who do you usually go to for health care? _____