Caldwell MEDICAL ASSOCIATES
TIGER CLINIC

STUDENT INFORMATION

Last Name: _____ First Name: _____ Full Middle Name_____
SS #: _____ Grade: _____ Birth date: _____
Address: _____ City/State/Zip: _____

PARENT / GUARDIAN INFORMATION

Mother: _____ Phone (H)_____ (W)_____ (C) _____Email _____
Father: _____Phone (H)_____ (W)_____ (C) _____E-mail_____
Guardian: _____Phone (H)_____ (W)_____ (C) _____E-mail_____
Emergency Contact:_____Relationship to Child: _____Phone (H)_____ (W)_____ (C) _____

All services (excluding first aid) provided at the CMA Tiger Clinic require parental consent. Please review this form carefully and complete all information that is requested. Return the form to your child's teacher. CMA Tiger Clinic cannot/will not provide services to your child without this signed consent (except for emergency first aid).

_____ Yes- I consent for my minor child to receive health care services provided by CMA Tiger Clinic in the school-based clinic as
(Initial) determined by the school-based clinic's staff.

- This consent will remain in effect until the end of the existing school year in which this consent was signed. The consent can we withdrawn at anytime.

- I confirm that I have the right to consent as the parent or legal guardian of the minor child as listed above. I understand that it is my responsibility to notify CMA Tiger Clinic about changes in my legal guardianship.

- I understand that Caldwell Medical Associates will notify me if my minor child received care in the school-based clinic, except in the event my minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky Revised Statute 214.185

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- I authorize CMA Tiger Clinic and each of their staff to communicate with my minor child's health care providers about health care services rendered by Caldwell Medical Associates at the school-based clinic.

- I authorize CMA Tiger Clinic to bill my health insurance provider for health care services rendered at the school-based clinic. If your insurance plan requires co-pays, these will be billed to the parent or guardian.

Insurance Subscriber's Name: _____ Date of Birth_____
SS# _____ Subscriber's Employer _____
Name of Health Insurance_____ Medical Care Number_____
(*Caldwell Medical Associates will need a copy of your card, front and back. Please attach to this consent form.*)

Student's Allergies (including medication allergies)_____
Pharmacy of Choice_____ Pharmacy Phone_____
Name of Child's Doctor/Office_____ Phone #_____
Doctor/Office Address_____

I authorize Caldwell Medical Center and/or any entity authorized by Caldwell Medical Center, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address, and/or mailing address and/or mailing address associated with my account.

Confidentiality: The information in my minor child's medical record is confidential and, unless as authorized by law, will not be released to any unauthorized person or agency without my authorization. I understand that it may be necessary for staff of the school-based clinic to confer among themselves and the school's health professional about treatment related to my minor child.

Signature of Parent or Legal Guardian_____ **Date**_____

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Health Information

The following information will aid the clinic providers in making an accurate assessment of you child in case of illness or emergency. Please check the appropriate space if you child has ever had any of the following:

____Measles	____ Chest Pain	_____ Sleep Problems
____Mumps	____ Scarlet Fever	_____ Stomach or Bowel Problems
____ Anemia	____ Seizures	_____ Joint or Muscle Pain/Stiffness
____Birth Defects	____ Unexplained Weight Loss	_____ Exposure to Tuberculosis
____ Diabetes	____ Unexplained Tiredness	_____Shortness of breath
____Chicken Pox	____ Persistent Cough	_____ Eyes, Ears, Throat Problems
____Rheumatic Fever	____ Unexplained Weight Gain	_____ Blood Transfusion
____ Asthma	____ Leukemia	____ Anaphylactic Episodes

If you answered yes to any of the above, please explain: _____

☐ Operations ☐ None

Type of Surgery: _____Hospital: _____Doctor:_____Date:_____

☐ Hospitalization ☐ None

Reason:_____Hospital:_____Doctor:_____Date:_____

☐ Serious Illness or Injury ☐ None

Type of Illness or Injury_____ Doctor:_____Date:_____

Does your child use tobacco? _____Yes_____No Alcohol?_____Yes _____No Drugs _____Yes _____No

Dentist's Name:_____ Address:_____Phone:_____

Does child receive regular dental care? _____Yes _____No

Last Doctor Visit Doctor_____ Reason:_____Date:_____

Please specify if any of the student's family members have had any of the listed health problems using this code:
S=Sibling, F=Father, M=Mother, GF=Grandfather, GM =Grandmother. Also identify the grandparents by P=Paternal and M=Maternal. (Example: the mother's parents would be listed as MGF for maternal grandfather.)

_____Cancer	_____Heart Disease	_____Anemia
_____Birth Defects	_____Kidney Disease	_____ Epilepsy
_____Stroke	_____Diabetes	_____ High Blood Pressure
_____ Tuberculosis		

Current Medications: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed and understand the CMA Tiger Clinic, Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Caldwell Medical Associates Tiger Clinic may update its Notice of Privacy Practices at any time. The Notice of Privacy Practices is available for download on the Caldwell Medical Center website.

Student Name (Printed)	Date
Parent/Guardian Name (Printed)	Relation to Patient
Parent/Guardian Name (Signature)	Date

I also authorize CMA Tiger Clinic and its affiliated providers to view my child's external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and read and understood the scope of my consent that I authorize access.

Parent/Guardian Name (Printed)	Relation to Patient
Parent/Guardian Name (Signature)	Date
Witness	Date