CONSENT TO TREAT

Client Name:	Client #	Date:

Switzerland County School Corporation partners with Harmony Health Primary Care to offer physical health services. Completion of this consent for treatment form is required for you (emancipated minors or students over 18) or your child to receive health services. School nursing and emergency services will be provided whether or not you choose to take part in these added services.

This primary care service will provide your child the opportunity to be seen by a licensed healthcare provider. Most of the services will be provided face-to-face at 1037 W. Main Street in Vevay. Some of the services may be provided via telemedicine when appropriate. You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any services to be provided. The school is willing to transport your child to the visit. An attempt to contact parents will be made prior to the initiation of each primary care visit and you can join your child's visit in person or via telemedicine.

This consent is for the treatment of yourself or your child by the Harmony Health Primary Care, a program of Community Mental Health Center (CMHC), hereafter referred to as Harmony Health. Harmony Health provides standard primary care services in person and through telemedicine.

In addition to the consent on file, an attempt will be made to contact the parent/guardian before each visit in an effort to receive verbal consent for the child to be seen.

Examples of services in primary care include physical exams (well-child, sports, work), care and treatment for illness/injury (strep throat, ear infections, flu, etc.), routine lab tests (some are read on-site, and others are sent to LabCorp), prescription medications, care for common health concerns (ex. Acne, menstrual problems, weight), care of chronic conditions (such as asthma, diabetes, seizure disorder), recommended screenings (vision, hearing, mental health, dental, etc.), health education and prevention, some vaccinations, and sports medicine.

I, the undersigned,

- Have received a brochure describing Harmony Health services.
- Give informed consent for myself or my child to participate in and receive treatment from a Harmony Health Primary Care provider with or without the presence of a parent/guardian.
- Acknowledge that care may be provided in person or via telehealth. The main difference between telehealth and in-person care is the provider's inability to have direct, physical contact with the patient. Also, the quality of telehealth transmission might affect the quality of health care services. The patient may stop using telehealth at any time without jeopardizing access to future care, services, or benefits.
- Acknowledge responsibility of payment of charges and fees not covered by insurance.
- Received a copy of the payment policy including sliding fee scales for CMHC Harmony Health.
- Understand the consent is valid until I provide Harmony Health with written directions otherwise.
- Acknowledge that I have been offered a copy of the Notice of privacy practices, which is located on CMHC's website.

- Authorize CMHC Harmony Health Primary Care program to provide my child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results with **Switzerland County School Corporation** health personnel for treatment, referral, and/or care coordination. To help coordinate care, I also authorize **Switzerland County School Corporation** to provide a copy of medical information or other relevant personal information within my child's school records to CMHC Harmony Health to facilitate the assessment of my child's health needs, coordinate my child's care, provide treatment or referral, and/or evaluate the health program and its services. I also agree to allow Harmony Health access to my child's individual academic, attendance, and behavior records for the current and prior school years so it can provide better services to my child. This permission expires when your child is no longer enrolled in SCSC or when it is terminated in writing.
- Consent, if my child has a primary care provider, to exchange of my or my child's health information with that primary care provider including any prescriptions they received.
- Understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If you have consented for your child to be tested, treated, or diagnosed with any such injury, disease, or illness, CMHC Harmony Health is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.
- For records related to alcohol and drug treatment, federal law prohibits recipient from making further disclosure of this information unless additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal law.
- Understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization for disclosure of my child's health information, it will not in any way prevent my child from receiving care or treatment from Harmony Health. A consent to treat is still required.
- Authorize the release of any information necessary to process insurance claims for payment of benefits to CMHC for Harmony Health Primary Care services.
- Authorize payment of benefits to CMHC for Harmony Health Primary Care services.
- Have provided details of all insurance policies that cover myself or my child.
- Consent to receive text messages for appointment reminders. I understand depending on my plan that I might incur charges for text messages.

I, Parent/Guardian/emancipated minors/student over 18, certify that I am of sound mind and body, that I have received information on the patient bill of rights and responsibilities, including the process for filing a grievance, that I understand and agree with the information contained in this consent form, including but not limited to the consent for health services/treatment and financial responsibility sections, and that I freely give my informed consent for my child to receive the recommended primary care services.

Signature of Parent/Legal Guardian/Emancipated Minor/Student over 18: ______________________________________

Print Name of Parent/Legal Guardian/ Emancipated Minor/Student over 18: _____________________________________

Relationship to the child/student: ____

Student/Patient Information		
Student Last Name:	Student First Name:	
Date of Birth:	Sex at Birth: ☐ Female ☐ Male	Social Security #:
Home Address:		City:
State:	Zip Code:	Phone Number:
School Name:		
Preferred Language:	Do you identify as Hispanic? ☐ Yes ☐ No	
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Native American/Pacific Islander ☐ Caucasian ☐ Declined ☐ Other:		
Name of Primary Care Provider, if applicable:		
Legal Guardian Information		
Guardian's Last Name:	Guardian's First Name:	
Date of Birth:	Social Security #:	
Home Phone #:	Cell Phone #:	
Employer:	Employer Phone #:	
Student/Patient Insurance Information		
Student/Patient has insurance: ☐ Yes ☐ No		
Name of Insurance Company:	Subscriber's Name:	
Group #:	ID #:	
Emergency Contact Information		
Name:	Relationship:	
Phone #:	May we leave a message: ☐ Yes ☐ No	
Preferred Retail Pharmacy Name:		
Address:		Phone #:

Harmony Health
Pediatric Health History Form – Initial Visit

Client #____________

Child's Name ____ Date of Birth ______________Age _______

Mother's Name ____ Father's name ____

Form filled out by _____________________ Date ______________________

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? ______________________________
Is the child yours by ☐birth ☐adoption ☐stepchild ☐other
Pregnancy complications ________________________________
Delivery by ☐vaginal ☐c-section
Reason for c-section ___________________________
Complications ________________________________
Was your child premature ☐No ☐Yes, born at __________ weeks
Complications __________________________________
Apgar scores 1 minute _________ 5 minutes ______________
Birth weight _________________ Length _________________
Other problems in the newborn period
____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease ___________________
- ☐ Wheezing or bronchiolitis ____________________________
- ☐ Seasonal allergies or eczema ________________________
- ☐ Food allergy __________________________________
- ☐ Recurrent ear infections ____________________________
- ☐ Pneumonia ______________________________________
- ☐ Urinary tract infections _____________________________
- ☐ Genetic syndrome _________________________________
- ☐ Seizures ____
- ☐ Anemia ____
- ☐ Broken bone ____________________________________
- ☐ Intellectual disability or learning disability ___________
- ☐ Depression/anxiety _______________________________

Other chronic medical conditions
____
Has your child ever been hospitalized ☐No ☐ Yes (explain)
____
____
Previous surgeries and dates
____
Previous pediatrician ___________________________________
Please list any specialist your child is currently seeing and reason:
____
____
Previous surgeries and dates ____________________________

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
____
____
Current medications and dose:
____
____
Vitamins ____
Herbal supplements ____________________________________
Over-the-counter meds __________________________________

Development/Nutrition

At what age did your child: Sit alone _______________
Walk alone ______________ Toilet train(day) __________
1st period (females) _______
Was your child breastfed ☐ No ☐Yes, how long? ________
Has your child had any unusual feeding/dietary problems? Explain.
____
____
____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step______
☐Siblings (# _____) ☐ Grandparents ☐ Other ___________
Mother's occupation ______________________________________
Father's occupation ______________________________________
Child's parents are ☐ married ☐ unmarried ☐ divorced ☐other
Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny
Days per week in childcare (not with parents) _____________
School's name _____________________________ Grade ______
Any concerns about school performance? ☐ No ☐ Yes, explain
____
Do any household members smoke ☐ Yes ☐ No
How many hours per day does your child spend:
Watching TV _______Computer _______Video games ______
Sports/exercise: Type ______________________________________
How often? __________________ How long ___________min

Family History

Do any family members have any of the following conditions:

Condition	*Mother*	*Father*	*Sibling*	*Grandparent*
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____________	☐	☐	☐	☐

Please explain all the positives.
____
____
____

Review of Systems (Check all that apply)

Constitutional
☐Fever, chills ☐ Fatigue
☐ Unexplained weight loss/gain
☐Excessive thirst

Ear, Nose, and Throat
☐ Loud voice, hearing problem
☐ Mouth-breathing, snoring
☐Ear pain
☐ Frequent runny nose

Respiratory
☐ Cough, short of breath
☐ Chest tightness, wheeze

Musculoskeletal
☐Muscle pain, weakness
☐ Joint pain, swelling
☐ Bone pain

Other (eye,skin,blood)
☐ Blurry vision ☐ Squinting
☐"Crossed" eyes ☐ Itchy eyes
☐ Rashes ☐ Abnormal moles
☐ Abnormal bruising, bleeding

Gastrointestinal
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain

Cardiovascular
☐ Chest pain, palpitations
☐ Tires easily with exertion
☐ Fainting

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Vaginal or penile discharge

Neurologic
☐ Headaches ☐ Seizures
☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
☐ Anxiety/stress ☐Depression
☐ Sleep problem ☐ Anger concern
☐ Concerns with attention, impulsivity

Reviewed by ________________________________ date _____________