WISH PARENTAL PERMISSION FORM

School Year 2017-2018 (July 1, 2017 – June 30, 2018)

Student Name________________________________ School Name________________ Grade_____

Sex (circle one): M F Date of Birth__________ Social Security #________________ Ethnicity: Hispanic Non Hispanic

Race (circle one) White Black American Indian Native Alaskan Asian Native Hawaiian Other Pacific Islander

Address________________________________ City________________ State_____ Zip_________

Name of Parent/Legal Guardian*____________________________ Relationship to Student________________

Home Phone #________________ Cell phone # ________________email address________________________

Employer____ Work Phone #____________________

Student's Physician______________________________________ Office Phone #____________________

Preferred Pharmacy ______________________________________ Phone # ________________________

Student Dentist________________ Date of last visit ______________Phone #________________________

MEDICAL HISTORY

Is your child allergic to any medications or foods? ☐ Yes ☐ No If yes, please list ______________________________

Is your child currently taking any medicine? ☐ Yes ☐ No list medication________________________

Has your child ever been hospitalized overnight/or had a serious injury? ☐ Yes ☐ No

Age /Reason for hospitalization____

	Yes	No	Age
ADHD/learning disability	☐	☐	____
Allergies/hay fever	☐	☐	____
Asthma	☐	☐	____
Bladder or kidney infections	☐	☐	____
Blood disorder/sickle cell anemia	☐	☐	____
Cancer	☐	☐	____
Depression	☐	☐	____
Diabetes	☐	☐	____
Eating Disorder	☐	☐	____
Emotional Disorder	☐	☐	____
Hepatitis (liver disease)	☐	☐	____
Headaches/migraines	☐	☐	____
Low iron in blood (anemia)	☐	☐	____
Pneumonia	☐	☐	____
Rheumatic fever or heart disease	☐	☐	____
Scoliosis	☐	☐	____
Seizures/epilepsy	☐	☐	____
Stomach problems	☐	☐	____
Tuberculosis (TB)/lung disease	☐	☐	____
Mononucleosis (mono)	☐	☐	____
Hyperthyroid/hypothyroid	☐	☐	____
Other:________________	☐	☐	____

Family history (parents, brothers, sisters, grandparents, aunts, or uncles), living or deceased, had any of the following problems

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	______	______________________
Arthritis	☐	☐	☐	______	______________________
Birth defects	☐	☐	☐	______	______________________
Blood disorders/sickle cell anemia	☐	☐	☐	______	______________________
Cancer	☐	☐	☐	______	______________________
Depression/mental health	☐	☐	☐	______	______________________
Diabetes	☐	☐	☐	______	______________________
Drinking problem/alcoholism	☐	☐	☐	______	______________________
Drug addiction	☐	☐	☐	______	______________________
Endocrine/gland disease	☐	☐	☐	______	______________________
Heart attack/stroke before age 55	☐	☐	☐	______	______________________
Heart attack or stroke after age 55	☐	☐	☐	______	______________________
High blood pressure	☐	☐	☐	______	______________________
High cholesterol	☐	☐	☐	______	______________________
Kidney disease	☐	☐	☐	______	______________________
Learning disability	☐	☐	☐	______	______________________
Liver disease	☐	☐	☐	______	______________________
Smoking/lung disease	☐	☐	☐	______	______________________
Obesity	☐	☐	☐	______	______________________
Seizures/epilepsy	☐	☐	☐	______	______________________

WISH PARENTAL PERMISSION FORM

WE MUST HAVE YOUR SIGNATURE AND REQUESTED INSURANCE INFORMATION BEFORE YOUR CHILD CAN RECEIVE SERVICES.

As the parent or legal guardian of (**student name**) ____, I hereby give my permission for comprehensive health care and treatment and certify that the medical history given on the previous page is accurate to the best of my knowledge. (NOTE: See WISH brochure for services provided) WISH upholds the confidentiality of all patients.

PARENT/GUARDIAN NAME (PRINTED) ____

PARENT/GUARDIAN SIGNATURE ____

STUDENT SIGNATURE____

Insurance information is only required for medical services provided by the Nurse Practitioner. No one will be denied care due to inability to pay. Please **circle** which pay source your child has: **Medicaid** **Insurance** **Self-pay**
Please provide the following information if applicable:
Medicaid Number__________________________________
Insurance Company _______________________________ Plan Name _______________________________________
Policy Holder Name ___________________________________
Group # ___________________________________ Policy # ____
***You may send your insurance or Medicaid card to WISH and we will be happy to make a copy for child's medical record. We will immediately return the card to your child**.

AUTHORIZATION FOR MEDICAL RELEASE: I give authorization for Goldsboro Pediatrics P.A., Wayne County Public Schools, Wayne County Health Department, Wayne Memorial Hospital, any primary physician, or medical facility who has provided medical services to my child to release medical information to:
Wayne Initiative for School Health "WISH"

** ____ ______________________
PARENT SIGNATURE **DATE**

I authorize Wayne Initiative for School Health to provide information to insurance companies, physicians, hospital, preventative/mental health counselor or health department concerning illness and treatment of my child. I authorize the release of medical information necessary to provide medical services or process insurances claims and hereby assign all payments of benefits to Wayne Initiative for School Health (WISH) and/or contracted agencies/individuals for services rendered

** ____ ______________________
PARENT SIGNATURE **DATE**

NUTRITION:

I give permission for my child to receive nutritional counseling services with a Registered Dietician affiliated with the WISH Health Centers for (1) nutritional counseling, (2) weight management, and (3) instruction on healthy eating habits.

** ____ ____________________
PARENT SIGNATURE **DATE**

COUNSELING:

I give permission for my child to receive counseling services in the WISH Health Center with a Licensed Counselor affiliated with WISH. Students may be referred (1) to help avoid risky behavior, (2) to deal with grief or loss, (3) for problems with grades and behavior, (4) for self-esteem and emotional needs. Upon referral for services, the Counselor will provide to the student, the parents: pertinent information, plans, and contact numbers. If the student is transferred to a different school with a WISH Center, counseling information may be transferred to another mental health provider in that WISH Center.

** ____ ______________________
PARENT SIGNATURE **DATE**

EMERGENCY TREATMENT

In emergency situations requiring acute care, WISH personnel will contact the parent and the Emergency Medical System for transport of the student to the appropriate medical facility. If the parent or guardian is not available whom should we contact? Please list two emergency contacts:

Name	**Phone Number**	**Relationship to Student**.
1.__________________________	______________	__________________
2.__________________________	______________	__________________

5/99, 11/99, 02/00, 03/00, 05/00, 03/01, 04/01, 07/01, 07/03, 04/06, 09/06, 04/07, 05/08, 03/09, 04/10, 04/11, 05/12, 05/13, 05/14, 02/15, 05/16, 03/17