Affinia Healthcare
1717 Biddle Street • St. Louis, Missouri 63106
Main Number: 314-898-1700 • www.affiniahealthcare.org

SCHOOL BASED MEDICAL TREATMENT CONSENT FORM

Affinia Healthcare School Based Medical team can provide medical services at your child's school. Your child's participation is voluntary. **In order for your child to receive these services; you must provide all information requested below. This consent is valid for two years.**

Demographics

Child's Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Sex: □Male □Female **Date of Birth**_____/_____/_____ **Social Security #:** _____-_____-_____

Home Address: _____ **Zip:**_____

School_____ **Grade**_____

Parent/Guardian Name (please print):_____ **Relationship:**_____

Cell Phone #: (____)_____ **Home Phone #:** (____) _____ **Work Phone #:**(____) _____

Email Address: _____ **Language spoken at home:**_____

Emergency Contact: _____ **Relationship:** _____

Phone #: (_____) _____

Ethnicity, Race, and Housing *(For Statistic Purposes Only)*

Ethnicity: □ Hispanic or Latino □ Non Hispanic or Latino

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Does your family participate in a Housing Assistance Program? □Yes □ No □ Decline to report

If yes, which type: □Public Housing □ Section 8 Housing □ Housing Voucher Program □ Subsidized Housing
□ Other (please list type_____)

Does your family live in a Homeless Shelter or without housing at this time? □Yes □ No □ Decline to report

Health History: Please check any history of/or difficulty with any of the following:

	Anemia		Diabetes		Hearing Disorder		Mental Disorder
	Asthma		Ear Infections (frequent)		Heart Murmur		Pregnancy
	Back Problems/Scoliosis		Ear Surgery		Hepatitis		Physical Problems
	Behavioral Issues		Eczema		High Blood Pressure		Seizures/Epilepsy
	Bleeding Disorder		Eye/Vision Problems		HIV/Aids		Sickle Cell Disease
	Congenital Heart Defect		Eye Surgery		Kidney Problems		Tuberculosis (TB)
	Cystic Fibrosis		Fainting		Lead Poisoning		Other_____
	Dental Problems		Headaches (frequent)		Liver Disorder		**None of these listed**

Allergies, please describe type: □ Food_____ □ Latex_____
□Medication_____ Seasonal_____ □ Other_____
Describe type of reaction:_____

Hospitalization date(s), please describe problem:

Surgery date(s), please list reason for surgery:

Please explain any item checked above:

Please list any medications your child is taking:

Any other concerns or comments:_____

Child's Last Name: _____ **First Name:**_____

DOB:_____/___/_____

Insurance

Does your child have a medical doctor? □**Yes** □**No** If yes, when was the last time your child saw his/her doctor for a physical or well child exam? Provider/Clinic: _____ Date:_____/____/_____

Preferred Pharmacy (If M.D. or Nurse Practitioner feels your child would benefit from medications):
Pharmacy Name:_____Pharmacy Location: _____Phone: _____

Does your child have health insurance? □**Yes** □ **No**

Missouri Medicaid/Mo Health Net □**Yes** □**No** If yes, Plan or DCN #_____

Other Medical Insurance □**Yes** □**No** If yes, Plan Name and #_____

Permission for Affinia School Based Services

Medical Services: This may include completing pediatric comprehensive medical histories and/or physical examinations, sports physicals, immunizations (scheduled and CDC recommended age-appropriate vaccines will be administered), vision and hearing screenings, referrals for specialty care, diagnosing and treating acute and chronic medical problems, writing prescriptions for medications, lab testing and interpreting test results. In addition, a complete asthma check-up consisting of provider examination, spirometry, an asthma action plan, and completion of permission to carry/administer documentation for those students that qualify can be performed.

* Physical exams may require a child to be partially unclothed during the exam. Parents are welcome to be present. Girls are encouraged to wear a bra or swim suit top

Please note, this consent is valid for two years

I give permission for Affinia Healthcare School Based Team to provide services for my child. I verify, I have read the information regarding the notice of Privacy Practices (HIPAA).

I give consent for Affinia Healthcare to use and disclose my child's health information to people involved in my child's care, also including my child's regular doctor and school nurse.

I give consent for payment of authorized insurance carriers to be made on my behalf of Affinia Healthcare for any services furnished to my child.

Parent/Legal Guardian Name (print):_____ **Date:**_____

Parent/Legal Guardian (signature): _____ **Date:**_____

Provider Review (signature):_____ Date: _____

Support Staff Review (initial/date):_____/_____ _____/_____ _____/_____

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ___/___/___ (month / day / year)

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention

immunization action coalition
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (4/19)

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1717 Biddle Street
St. Louis, MO 63106

Notice of Privacy Practices
Written Acknowledgement Form

About Our *Notice of Privacy Practices*

We are committed to protecting your personal health information in compliance with the law. Our *Notice of Privacy Practices* states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- Our right to change our *Notice of Privacy Practices*
- How to file a complaint if you believe your privacy rights have been violated
- The conditions that apply to uses and disclosures
- The person to contact for further information about our privacy practices

I have been informed of Affinia Healthcare's *Notice of Privacy Practices.*
I am aware that I have a right to receive a written copy of Affinia Healthcare's *Notice of Privacy Practices* upon request.

DOB: _____

_____ _____
Print: Full Name of Patient Medical Record #

_____ _____
Signature of Patient/Guardian/Legal Representative Date

_____ _____
Print: Name of Guardian/Representative Title/Relationship

_____ _____
Print: Witness Title

MSHSAA Preparticipation Physical Forms/Procedure

Medical History Form (Step 1): Issued to Student/Parent(s)/Guardian, Completed by Student/Parent(s)/Guardian, Taken to Healthcare Professional (MD/DO/ARNP/PA/DC), Retained by Healthcare Professional.

Note: If the student is under 18 years old, the Medical History questions are to be completed with assistance from parent(s)/guardian(s).

Note: The health care professional (MD/DO/ARNP/PA/DC) who completes the pre-participation examination (PPE) shall keep this Medical History form in the patient's files for their records.

This Medical History form is NOT returned to the school.

MEDICAL HISTORY	
Name:	Date of Birth:
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):
List past and current medical conditions:	
Have you ever had surgery? If yes, list all past surgical procedures:	
Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional):	
Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects):	

PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems (Circle response).

	Not at All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge:	0	1	2	3
Not being able to stop or control worrying:	0	1	2	3
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed or hopeless:	0	1	2	3

A sum of ≥3 is considered positive on either subscale (questions 1 and 2, or questions 3 and 4) for screening purposes.

(Medical History Continued – Next Page)

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you, or does someone in your family, have sickle cell trait or disease?		
24. Have you ever had, or do you have, any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended, that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

IF "YES," EXPLAIN ANSWERS HERE

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Student:
Signature of Parent(s) or Guardian:
Date: