St Luke's
UNIVERSITY HEALTH NETWORK

MOBILE VAN HEALTH SERVICES
STUDENT INFORMATION & CONSENT

PLEASE COMPLETE ALL PAGES

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ ☐ Male ☐ Female

PRIMARY HEALTH CARE SERVICES:

___ **YES,** I consent for my child to receive **MEDICAL CARE** at the St. Luke's mobile van, including routine well childcare, appropriate immunizations, and treatment for illness or injury including over the counter medications unless emergency services are needed.

MEDIA CONSENT:

___ **YES,** I hereby consent for St. Luke's University Health Network and its affiliates to take photographs of my child and interview my child, and to make video and/or audio recordings of my child.

___ **NO,** I do not wish for my child to be photographed, videotaped and/or interviewed by St. Luke's.

By signing this consent, I agree to the terms and conditions regarding the **SHARING of HEALTH INFORMATION** as explained in the accompanying **PROGRAM DESCRIPTION** pages. I have received the **Notice of Privacy Practices,** which is included in this packet.

This consent will be in effect until the student graduates or ceases to be enrolled at the student's present school or until this consent is revoked by the parent/legal guardian by sending a written notification to the student's school nurse.

X_____ _____ _____ _____

Parent/Guardian Signature | Date | Time | Parent/Guardian's Printed Name

_____ _____ _____ _____

Student's Signature (if 18 or older) | Date | Time | Student's Printed Name

STUDENT INFORMATION MOBILE VAN HEALTH SERVICES

Name of Parent/Guardian: _____ Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security Number: _____

Address: _____

Street Number *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____

Other than Parent / Legal Guardian

Student's Social Security Number (if known): _____

Name of Medical Insurance: _____ Insurance Number: _____

Name of Dental Insurance: _____ Insurance Number: _____

Name of Vision Insurance: _____ Insurance Number: _____

Regular Medical Doctor or Clinic: _____

Address: _____ Phone Number: _____

Date of last complete yearly physical examination: _____

Regular Dentist/Clinic: _____ Phone Number: _____

Date of last routine dental exam and cleaning: _____

Does your child wear glasses or contacts and if so, date of last eye exam: ☐ Yes ☐ No Date: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

(Please continue to the next page)

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UNIVERSITY HEALTH NETWORK

MOBILE VAN HEALTH SERVICES
STUDENT INFORMATION & CONSENT

Please complete and return to the school health room along with the completed consent form.

HEALTH HISTORY FORM STUDENT'S NAME: _____

1. Is your child allergic to any medications? ☐ Yes ☐ No
   If yes, please list medications: _____
2. Does your child have any severe food allergies? ☐ Yes ☐ No
   If yes, please list foods: _____
3. Does your child have any other allergies? ☐ Yes ☐ No
   If yes, please list: _____
4. Does your child currently take any medications? ☐ Yes ☐ No
   If yes, name of medications: _____
5. Has your child had any operations, serious injuries or hospitalizations? ☐ Yes ☐ No
   If yes, please explain: _____
6. Does your child have or had any of these problems? (Please check all that apply)

☐ Asthma or wheezing	☐ Heart Murmur	☐ Pregnancy
☐ Bleeding problems	☐ Heart Trouble	☐ Sinus Trouble
☐ Cancer- type: _____	☐ High Blood Pressure	☐ Stroke
☐ Diabetes	☐ Kidney Disease	☐ Taking Phen Phen
☐ Eye Problems	☐ Liver Disease	☐ Ulcers
☐ Joint Problems/Replacement	☐ History of Rheumatic Fever	☐ Psychiatric Treatment

Please explain problems checked above: _____

SCHOOL CONCERNS

Please check yes or no below and explain any yes answers on the line provided:

Is your child in any special education classes? ☐ Yes ☐ No _____

Does your child get into trouble often at school? ☐ Yes ☐ No _____

Thank you for your time used in completing your child's health history and consent form.

(Please continue to the next page)

St Luke's
UNIVERSITY HEALTH NETWORK

MOBILE VAN HEALTH SERVICES
HIPAA PRIVACY AUTHORIZATION FORM
HEALTH SERVICES

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization to Disclose.** I authorize St. Luke's University Health Network to use and disclose health information about my child obtained by St. Luke's in providing health services to my child. The purposes of such uses and disclosures would be for communicating with my child's school and its employees and agents, including the guidance counselors and school nurse, as the Network and the school determine is in my child's interests.

2. **Refusal to Sign.** I understand that I may refuse to sign this authorization. St. Luke's may not refuse to treat my child based on my refusal to sign this Authorization.

3. **Expiration of Authorization.** This Authorization shall be in force and effect until my child graduates or ceases to be enrolled at his/her present school, at which time this Authorization expires. Once this Authorization has expired, St. Luke's may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.

4. **Revocation of Authorization.** I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization. If I wish to revoke this Authorization, I will send a written request to: St. Luke's University Health Network, 801 Ostrum Street, Bethlehem, Pennsylvania 18015, Attention: Director, Community Health.

5. **Further Disclosure.** I understand that information used or disclosed pursuant to this Authorization may be further reproduced, copied or disclosed by those who receive or view the information, and the laws governing patient privacy may no longer protect the information.

X_____ _____ _____ _____

Signature of Parent or Guardian | Date | Time | Printed Name of Parent or Guardian and his or her relationship to child

_____

Child's Name

St Luke's
UNIVERSITY HEALTH NETWORK

MOBILE VAN HEALTH SERVICES
HIPAA PRIVACY AUTHORIZATION FORM
MEDIA RELEASE

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization to Disclose.** I authorize St. Luke's University Health Network to use and disclose photographs, interviews, or video and/or audio recordings of my child relating to services provided by the St. Luke's mobile health van, along with any health information related to those services (such as the reason my child was visiting the mobile van). The purposes of such uses and disclosures would be for the promotion of St. Luke's and its services, patient education, discussion of newsworthy topics, community reports, donor materials, or otherwise, whether appearing in newsletters, web pages, forums, advertising, publications, displays, written or audio media releases, or other formats.

2. **Refusal to Sign.** I understand that I may refuse to sign this authorization. St. Luke's may not refuse to treat my child based on my refusal to sign this Authorization.

3. **Expiration of Authorization.** This Authorization shall be in force and effect until my child graduates or ceases to be enrolled at his/her present school, at which time this Authorization expires. Once this Authorization has expired, St. Luke's may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.

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Signature of Parent or Guardian | Date | Time | Printed Name of Parent or Guardian and his or her relationship to child

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Child's Name