"We Put Wheels On Wellness!"
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NAME_____

SCHOOL_____

TEACHER_____ GRADE_____

CONSENT FORM

In order for your child to receive medical, dental, and/or behavioral health services with Kids'-Doc-On-Wheels, Inc. (KDOW), a mobile health center, this consent form must be completed and proper documentation of insurance obtained. Please complete all sides of this consent form. Please initial the area for acknowledgment of receiving the health center's Notice of Privacy Policies.

I hereby voluntarily give my consent for _____ to receive medical, dental, and/or behavioral health services with Kids'-Doc-On-Wheels. I further authorize any physician or physician-designated health professional working for the mobile health center to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care.

I understand that my signing this consent allows the physician and professional clinic staff of **KDOW** to provide the aforementioned comprehensive health services for my child. I authorize periodic dental examinations for my child, which may include photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child's dental health.

I authorize release of information from my son or daughter's medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care, including referrals and/or emergency services. I also authorize the **Kids'-Doc-On-Wheels** mobile health center to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason, in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to uninsured students will be based on a sliding fee scale**. No patients will be denied services because of inability to pay.**

Finally, I give consent to share my child's health information between the school nurse and the mobile school based health center, in order to obtain information needed to provide the best healthcare possible.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the center by contacting the mobile health clinic staff at **contact@kidsdoconwheels.org**. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

_____	_____	_____
Name of Patient (PLEASE PRINT)	**Patient's Date of Birth**	**Today's Date**
_____	_____	_____
Parent or Legal Guardian (PLEASE PRINT)	**Parent or Legal Guardian (PLEASE SIGN)**	**Today's Date**

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Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date in order for your child to receive services from the Mobile Health Center. It is your responsibility to notify us immediately of any changes in address, phone numbers, or insurance.

Today's Date: _____

Patient's Name_____ _____ _____
First Middle Last

Date of Birth _____ Social Security Number_____-_____-_____ Sex_____ Race_____

Primary Language _____ Remedial/Special Education Yes No

Consent to receive texts? Yes or No Consent to access the Patient Portal? Yes or No Email Address_____

Home Phone #_____ Cell Phone # _____ Work Phone # _____

Address_____Apt.#_____

City _____ State _____ Zip _____ Birth Country _____

How long at present address? ____Years ____Months How long at previous address? _____Years _____Months

Is present housing: ____Permanent___ Temporary _____ Shelter _____ Institution _____None ____Unstable ____Foster Care ____Other

Who lives with student, please list everyone who lives in home including yourself:

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does anyone in the home smoke cigarettes or use tobacco products? Yes or No

Please check an option, if applicable:

____ Within the past 12 months, we worried whether our food would run out before we got money to buy more.

____ Within the past 12 months, the food we bought just didn't last and we didn't have money to buy more.

Emergency Contact Name _____ Relationship to Patient_____
Phone Number _____

Next of Kin Name _____ Relationship to Patient_____
Phone Number _____

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WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE?

PLEASE PROVIDE PROOF OF INSURANCE OR YOU MAY BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. PLEASE LIST ALL INSURANCE COVERAGE THE CHILD IS ELIGIBLE FOR.

Name of Policy Holder/Guarantor _____ Date of Birth _____ Relationship to Patient_____

Name of Insurance _____Policy #_____ Group #_____

Insurance Address_____

Secondary Insurance Name _____ Policy # _____ Group#_____

Insurance Address_____

Please check if applicable: _____ Not Insured

GENERAL HISTORY

Does the patient have any allergies to medications, food and /or anything else?

List here _____Reactions _____

Please List Daily Medication Names and Dosages

_____

_____

Pharmacy Name _____ Phone Number _____

Any Health Problems Under Treatment? ___ Yes ___No
If yes, explain _____

Specify where treatment was received? _____

Has your child seen a doctor in the last year? _____Yes ____No
If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times
Where? _____
Why? _____

Has your child used a Hospital Emergency Room in the last year? ____Yes ____No
If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times
Where? _____
Why? _____

Was your child in the hospital overnight in the last year? ____Yes ____No
Where? _____
Why? _____How Long_____

Where do you take your child for Primary Care/Routine Care and Acute Care/Emergency/Sick visits? In the columns below, please check the box(es) that apply and fill in names, addresses, and phone numbers.

	PRIVATE DOCTOR OR CLINIC	HOSPITAL OUTPATIENT CLINIC	NAME / ADDRESS/ PHONE NUMBER
PRIMARY CARE/ROUTINE CARE			
ACUTE CARE EMERGENCY SICK VISITS			

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Family History

Please specify who has or had any disease listed below by using abbreviations below.
(Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)

	WHO		WHO
Allergies	_____	Early Childhood Death	_____
Asthma	_____	Heart Trouble	_____
Birth Defects	_____	High Blood Pressure	_____
Blood Disorders/Anemia	_____	Kidney/Bladder	_____
Cancer/Tumors	_____	Learning/Behavioral Disorder	_____
Cystic Fibrosis	_____	Lung Diseases	_____
Death Under Age 50	_____	Mental/Emotional Disorder	_____
Diabetes (before 40)	_____	Muscle Disease/Weakness	_____
Ear/Eye Disorder	_____	Seizures	_____

Family History (Cont'd)

Tuberculosis _____

There is no family history
of the above diseases. _____

CHILD'S MEDICAL HISTORY

ILLNESS HISTORY

Abdominal Pain	__Yes __No
Allergies	__Yes __No
Allergic to Drugs	__Yes __No
Anemia	__Yes __No
Asthma	__Yes __No
Broken Bones	__Yes __No
Cancer	__Yes __No
Chicken Pox Age_____	__Yes __No
Constipation/Diarrhea	__Yes __No
Diabetes	__Yes __No
Ear Infections	__Yes __No
Ear Problem	__Yes __No
Eye Problem	__Yes __No
Fainting Spells/Knocked Out	__Yes __No
Frequent Colds	__Yes __No
Frequent Sore Throat	__Yes __No
Headaches	__Yes __No
Hearing Aid	__Yes __No
Heart Murmur	__Yes __No
Heart Problems	__Yes __No
Hepatitis	__Yes __No
High Blood Pressure	__Yes __No
Injuries (major)	__Yes __No
Kidney/Urinary Tract Problems	__Yes __No
Lung Problems	__Yes __No
Meningitis	__Yes __No
Menstrual Problems	__Yes __No
Menstruation Started Age_____	__Yes __No
Musculoskeletal Problems	__Yes __No
Obesity	__Yes __No
Other Blood Disorders	__Yes __No

BEHAVIORAL HEALTH

Alcohol	__Yes __No
Bedwetting	__Yes __No
Depression	__Yes __No
Discipline Problems	__Yes __No
Inhalants	__Yes __No
Learning Disability	__Yes __No
Nightmares	__Yes __No
Overactive/Hyperactive	__Yes __No
Shy	__Yes __No
Sleeping Problems	__Yes __No
Slow Development	__Yes __No
Smoker	__Yes __No
Other Behavior Problems	__Yes __No
Other Drugs _____	__Yes __No
Other Mental Problems	__Yes __No
Other_____	__Yes __No

Explain any behavioral or mental problems noted: _____
_____
_____

Please list any **present** concerns**:**
_____
_____
_____

***Explain any illnesses marked yes:
_____
_____
_____
_____

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Other Respiratory Problems	__Yes __No
Physical/Sexual Abuse	__Yes __No
Premature Birth	__Yes __No
Problems Walking	__Yes __No
Seizures/Epilepsy	__Yes __No
Serious Acne	__Yes __No
Serious Digestive Problems	__Yes __No
Sickle Cell Disease	__Yes __No
Sickle Cell Trait	__Yes __No
Skin Rashes	__Yes __No
Speech Problem	__Yes __No
Stomach Ulcers	__Yes __No
Thyroid Problems	__Yes __No
Tuberculosis	__Yes __No
Wears Glasses	__Yes __No
Other_____	__Yes __No

DENTAL

Dental Problems	
Pregnant	__Yes __No
AIDS/HIV	__Yes __No
Rheumatic Fever	__Yes __No
Hemophilia	__Yes __No
Underweight	__Yes __No

When was your child's last dental visit?
_____

How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? _Yes _No

Has your child had any injury to the teeth or jaws? __Yes __No

Does your child have a finger or thumb sucking habit? __Yes __No

DENTAL HEALTH (Cont'd)

Generally speaking, what has been your child's experience with a dentist?
__Good __Bad __Very Bad __No experience (the child's first visit)

Eating Problems	__Yes __No
Thumb Sucking	__Yes __No

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Medical Information Release Form (HIPAA Release Form)

Patient's Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Parent_____
[ ] Legal Guardian_____
[ ] Other relatives_____
[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:
[ ] my home _____
[ ] my work_____
[ ] my cell number:_____
[ ] other number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other _____

The best day to reach me is _____between_____ am/pm & _____am/pm.

Signed: _____ Date: _____/_____/_____

How would you like to receive information about your child's appointment (follow-up)?

[ ] Home Phone [ ] Mobile Phone [ ] Patient Portal

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CONSENT FORM FOR THE USE OF TELEMEDICINE

Patient's Full Name: _____

Patient's Date of Birth: _____ Georgia Medicaid ID#: _____

1. PURPOSE: The purpose of this form is to obtain your consent for your child to participate in a telemedicine consultation in connection with the following procedure(s) and/or services: **Medical Services, Dental Services, and Behavioral Health Services.**
2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your child's medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of your child may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio, and/or photo recordings may be taken of your child during the procedure(s) or service(s).
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to your child's medical information and medical records, apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your child's right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES, & BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your child's healthcare practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

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NAME_____
SCHOOL_____
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CONSENT FORM FOR THE USE OF TELEMEDICINE CONT'D

I grant consent for my child to participate in a telemedicine consultation for the aforementioned procedure(s).

Signature: _____ Today's Date: _____

If signed by someone other than the patient's parent/legal guardian, indicate relationship: _____

Witness Signature: _____ Today's Date: _____

I understand the **Kids'-Doc-On-Wheels** mobile health center is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations. If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by this mobile health center only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I HAVE RECEIVED THE KIDS'-DOC-ON-WHEELS MOBILE HEALTH CENTER'S NOTICE OF PRIVACY PRACTICES.

PLEASE INITIAL _____ **TODAY'S DATE:** _____

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SCHOOL_____

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CONSENT FORM AND WAIVER (PATIENT & FAMILY)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND OTHER PERSONAL INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEO) FOR MARKETING PROMOTION, MEDIA AND PUBLIC RELATIONS PURPOSES

I hereby give consent to Kids'-Doc-On-Wheels, Inc. (hereinafter "KDOW"), its affiliates, media outlets, community organizations, and/or third parties providing service to KDOW to take and use images (photographs or video) or sounds recordings of me and/or the minor patient or person named below for whom I am giving consent (the "Patient"), and to disclose information about me and/or the Patient, to or in any public media, including radio, television, internet, social media, or print, or in a KDOW publication. I understand that the intended use of such images and information is for advertising, marketing, fundraising or promotional purposes of KDOW.

I understand that the information to be disclosed may include protected health information about the Patient's treatment at KDOW obtained from interviews of the family, physicians and KDOW personnel, or from the patient's medical records and I hereby waive the right to or interest in the confidentiality of this information or images taken and disclosed to the public, as contemplated in this release. I understand that the information disclosed pursuant to this release may be re-disclosed and no is longer protected by the federal privacy regulations.

I acknowledge that this consent and authorization for release of confidential information is being made solely for the benefit of KDOW and without any expectation of compensation or other benefit to the Patient or the family thereof. While unlikely, KDOW may receive direct or indirect remuneration from a third party. To the extent that any benefit accrues or might accrue to KDOW from the use of images or disclosure of information, I hereby and forever waive any interest in or claim to such benefits.

I hereby release and forever discharge KDOW (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in and to such information and materials.

I understand that I may refuse to sign this authorization, that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this release. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying KDOW in writing at: contact@kidsdoconwheels.org.

_____	_____
Name of Minor Patient or Person	Date of Birth of Minor Patient or Person
_____	_____
Name of Consenting Individual, Parent or Guardian	Relationship to Minor Patient or Person
_____	_____
Signature of Consenting Individual, Parent of Guardian	Phone Number

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