Valley-Wide Health Systems, Inc.

Parental Consent

School-Based Health Services

I give my consent for _____ _____
Child First Middle Last Name Child's Birth Date

to receive necessary and/or advisable health services from Valley-Wide Health Systems, Inc. (VWHS) staff at the Canon City School-Based Health Center (CCSBHC). I have received information explaining VWHS services at the CCSBHC, I understand the following services may be available and by checking the corresponding box next to each service type I consent for my child to receive these services:

☐ **Medical Services:** Physical exams and immunizations · Routine lab tests · Care for acute illness and injury · Prescription medications · Care of certain chronic conditions such as asthma and seizure disorder · pregnancy testing · diagnosis and treatment of STD/STI · Age-appropriate reproductive health services · Drug and alcohol prevention and education · Behavioral health assessment and referral to treatment · Follow-up care as needed

☐ **Dental Services:** Dental screenings, routine cleanings, sealants, and dental x-rays

Release of Information: The information in my child's medical record is protected health information and will not be released to any unauthorized person or agency without written consent by child's parent/guardian. I understand that CCSBHC may disclose health information for payment, treatment, and health care operations as described in VWHS's Notice of Privacy Practices, and otherwise as allowed by law. As allowed by Colorado law, my son or daughter may request that certain visits and health information remain "confidential." This means that, for me or any other part to have access to my child's medical records regarding such information, a written release must be completed by my child. I give permission for the CCSBHC staff to examine and/or copy my son's or daughter's school records including immunization records attendance, and other records that may assist the staff in helping my son or daughter.

CCSBHC Fees, billing, authorization, and consent: I hereby authorize payment directly to Valley-Wide Health Systems, Inc. for medical/dental benefits. I understand that I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I understand that if I have been issued a refund check and it is returned as undeliverable after reasonable attempts to contact have been unsuccessful, such check will be considered a donation to VWHS. I also agree that if I fail to cash a refund check within 1 year of issuance, the refund check will be considered as a donation to VWHS.

☐ I do not give consent for my child _____,
Child's First Middle Last Name

DOB _____ to receive any necessary and/or advisable health services
Childs Date of Birth

from Valley-Wide Health Systems, Inc. (VWHS) staff at the CCSBHC.

_____ _____
Parent/Guardian Signature Date