



HOMER

CENTRAL SCHOOL DISTRICT

Homer Central School District School Health Services Consent Form

Dear Parent/Guardian:

We are excited to share that Homer School District is growing our partnership with Cortland Regional Medical Practice, CRMP, to provide health services to students. These health services are over and above what the typical school nurse would provide.

We know that students' health and success in school are absolutely connected. We hope that by bringing services directly to students during the school day, we can proactively meet their health needs and support overall health, wellness and school attendance.

If you would like access to school health services for your child(ren), please complete the consent on the back of this letter and return to your child's school. CRMP Health Services staff cannot provide medical services and/or treatment without written consent. Please note: NYS mandated physical exams and screenings can be provided however, as appropriate, without consent.

Examples of services provided include:

- Medical care and treatment, including diagnosis of acute and chronic illness and disease.
- Medically prescribed laboratory test such as strep test, and some medications, such as antibiotics.
- Annual health assessment.
- Referrals for service not provided through school health services.
- Comprehensive physical examination including those for school, sports, working papers, etc.

(Consent not required)

We look forward to partnering with CRMP and health and wellness for all!

Sincerely,

Thomas M. Turck
Superintendent



Health Services Consent

Student name: _____ DOB: _____ School & Grade: _____

Parent/ Guardian Information

Mother/Guardian: _____ Cell/Home: _____ Work: _____

Father/Guardian: _____ Cell/Home: _____ Work: _____

Parent/Guardian Address: _____

Health Insurance (Please circle and complete, if applicable):

Medical Insurance: Uninsured Medicaid Private Insurance

Policy Holder's name and date of birth for private insurance: _____

Private Medical insurance policy number _____ Group Number: _____

Preferred Pharmacy: _____

Please check here if you would like to be contacted by Cortland Regional Medical Practice Patient Advocate for assistance with accessing health insurance benefits

Student's Health Status

Child's pediatrician: _____ Phone: _____ Date of last physical exam: _____

List of allergies: medicines, foods, bee stings, etc. _____

List of medications your child is currently taking _____

Has your child been hospitalized in the past year? Y / N If yes, why? _____

Has your child had any surgeries in the past year? Y/ N if yes, describe _____

I authorize Homer Schools and Cortland Regional Medical Practice Health Care providers to share student information as appropriate to ensure health care can be provided as needed to assist in the treatment and/ or continuity of care for my child. These records may include the following: immunization records, class schedules, parent contact, address, phone number, medical, behavioral and mental health conditions, health screenings, medications, health care plans, or attendance information. I authorize Cortland Regional Medical Practice Health Care providers to contact and share/receive medical information with my son/ daughter's primary care physician as part of school health services. I further grant approval for the health care provider to participate in student health care planning or attendance teams as needed. I hereby authorize the School Health Services provider to provide the services as indicated above. This consent will be in effect for one year from this date.

Parent/Guardian Signature

Date

Please return the signed, completed form to your child's school. If you have questions or need assistance, Please contact the school nurse or principal.