PARENTAL CONSENT FOR EXPANDED MEDICAL OR COUNSELING SERVICES

Maranacook School-Based Health Center 2017-2018

Please complete, sign and return this form by **September 15, 2017** if you would like your child to have **Expanded Medical Services** and/or **Counseling Services.** You may sign up for both or choose one or the other.

EXPANDED MEDICAL SERVICES:

I give consent for ______________________ (student's name) to receive medically necessary or recommended Expanded Medical Services from the clinical staff at the Maranacook School-Based Health Center. I understand these services will be available:

- Diagnosis and treatment of illnesses such as strep throat, mono, and ear infections;
- Diagnosis, treatment, and triage of injuries;
- Evaluation of recurring symptoms such as headaches or stomach pains;
- Assistance with chronic conditions such as asthma, eating disorders, or diabetes;
- Reproductive health care services including education and counseling, prescription contraception and contraception management, diagnosis and treatment of sexually transmitted infections, and pregnancy testing (for students 14 yrs. and older);
- Provision of routine lab tests including hemoglobin, cultures, and screenings for mono and strep;
- Rapid Assessment for Adolescent Services (RAAPS) - survey that identifies risky behaviors in teens and allows healthcare providers to help them make positive choices and prevent serious injury, disease and premature death.

In addition:

- I understand that **MAINEGENERAL MEDICAL CENTER** will bill my health insurance (MaineCare, Anthem, etc) for expanded medical services for each visit. I understand that billing works exactly as it does in my doctor's office. I also understand that if I do not have health insurance or have financial constraints, that my child can still go in for expanded medical services and that I can call Maranacook School-Based Health Center to discuss options for free services and/or payment options.
- I understand that the Health Center provides services that complement (but do not replace) those provided by my child's primary health care provider (PCP). If my child needs a service that the Health Center is unable to provide, I understand that Health Center staff will refer my child to my child's PCP for that service.
- If my child does not have a PCP, I understand that the Health Center staff will assist me in locating one.
- I understand that my child's Health Center records will be kept in a confidential manner; however, I acknowledge that the Health Center may disclose information to my child's PCP and other healthcare providers (including the school nurse) for treatment or continuity of care purposes, in accordance with applicable law.
- I acknowledge that the Health Center may disclose my child's health information to third party payers, such as MaineCare, Anthem or other health insurance companies, for billing and payment purposes, in accordance with applicable law.
- I have read and understand the cover letter accompanying this form, and am aware that more detailed information is available upon request as well as on the school website. I understand that **this consent is valid until Oct. 12, 2018**.

____ ___________________________

Signature of Parent/Guardian Date

COUNSELING SERVICES:

I give consent for ______________________ (student's name) to obtain medically necessary or recommended Counseling Services from the Kennebec Behavioral Health (KBH) staff at the Maranacook School-Based Health Center. I understand that such services may include counseling to my child for emotional or psychological problems, counseling and therapy for other mental health conditions, and substance abuse counseling and treatment. I understand that these services **will be billed separately by KBH**, and that counseling records related to such services will be maintained separately and confidentially by KBH.

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Signature of Parent/Guardian Date