Family Medicine Health Center- Meridian Schools Clinic

Consent Form

Student's Name ___________________________ DOB: ___________ Parent/Guardian Name: ____

AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN THE MERIDIAN SCHOOL CLINIC AND CHILD'S SCHOOL

I authorize Meridian School Clinic (MSC) to disclose certain protected health information about Minor to the school identified below ("School") under the following circumstances: i) the School is authorized to administer medications when School is in session; or ii) the School needs health information about the Minor to better support the Minor in the classroom. The information that is disclosed may include prescription information, treatment reports, lab tests, x-ray reports, accounting of visits, and other information directly related to the two stated purposes.

I consent to the release of my child's education records from West Ada District schools to MSC providers at the School-Based Health Center (SBHC) if necessary for treatment. I understand that the purpose of sharing these records with Meridian School Clinic- School-Based Health Center is to keep my child's SBHC providers informed of his/her academic program and progress in an effort to improve my child's success in school. This includes: Name of child, school, attendance, class schedule, disciplinary records and school health records.

This authorization automatically expires once the Minor no longer attends the School or if you revoke this authorization in a written document that is sent to the Health Center at the address above. Once health information is disclosed to the School, the information is no longer protected by the healthcare privacy regulations. Instead, the information becomes part of the Minor's education records and the School may not re-disclose the information without the prior written consent of the Minor's legal representative. Such consent must comply with FERPA (20 U.S.C. § 1232g; 34 CFR Part 99), a Federal law that protects the privacy of student education records. The Minor may still receive treatment at the Health Center even if you do not authorize the disclosure of information to the School.

My Child is currently enrolled in the following school:

Meridian Elementary 1035 NW 1st Street Meridian, ID 83642	Meridian Middle School 1507 W 8th Street Meridian, ID 83642	Meridian Academy 2311 E Lanark Meridian, ID 83642
Barbara Morgan STEM Academy 1825 W Chateau Dr Meridian, ID 83646	Crossroads Middle School 650 N Nola Road Meridian, ID 83642	Meridian High School 1900 W Pine Street Meridian, ID 83642
Chaparral Elementary School 1155 N Deer Creek Ln Meridian, ID 83642	Lewis and Clark Middle School 4141 E Pine Ave Meridian, ID 83642	**Other High School:**
Chief Joseph Elementary School 1100 E Chateau Drive Meridian, ID 83642	Lowell Scott Middle School 13600 W McMillan Rd Boise, ID 83713	
Frontier Elementary 11851 W Musket Drive Boise, ID 83713	Pathways Middle School 1855 E Heritage Park Lane Meridian, ID 83646	
Peregrine Elementary School 1860 W Waltman Street Meridian, ID 83642	**Other Middle School:**	
Ustick Elementary 12435 W Ustick Rd Boise, ID 83713		
Other Elementary School:		

AND

My Child's Primary Care Physician (if applicable)	Physician's Name: Clinic Name: Address: Office Phone Number Office Fax Number

By signing below I affirm that I have the authority to make health care decisions on behalf of the minor child identified above and understand and agree with the terms and conditions stated above. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

X ____ X __________________________

Parent, Personal Representative*, or adult student's signature Date

*if signed by a Personal Representative, please state the Personal Representative's authority to act for student.