Old Dominion University Community Care
Student Health Services
Parent Permission Form

Confidential information to be completed by parent in ink and returned to school/clinic

Student's Name _____ Student's SSN # _____
(Last) (First) (MI)

Student's Address _____
(City/State) (Zip Code)

Home Phone # _____ Parent's Phone Work # _____ Cell # _____

Student's Date of Birth _____ Sex: M ☐ F ☐ Race _____ Primary Language _____

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Contact phone # _____

Emergency Contact _____ Ph# _____ Relation to Student _____

Student's Primary Care Doctor _____ Ph # _____

Student's Dentist _____ Ph # _____

Student's Insurance _____ Policy Holder's Name _____

Insurance Policy # _____ Group # _____ Effective Date _____

Is the Student currently receiving any **medication/medical treatment** on a continual basis? Y ☐ N ☐
If **YES**, please specify type of treatment/medication and the physician involved:

_____

_____

Please list all **ALLERGIES** to food, medicine, etc. that the student may have:

_____

_____

☐ **Consent to Disclose Records:** Records maintained by the Franklin City Public Schools are considered "education records" and, as such, are governed by the Federal Family Educational Rights and Privacy Act ("FERPA"). The purpose of this consent is to obtain permission, in accordance with FERPA, from the Student's parent, legal guardian, or the Student, if the Student is 18 years or older, for the disclosure of the Student's education records related to those health care services provided by ODU Community Care.

By my signature below, I hereby request and authorize the ODU Community Care to:

(1) release information related to health care services provided to the Student to the appropriate third-party payor for payment purposes; and

(2) exchange information pertaining to the Student's School Entrance Health Form, and related immunizations and school entrance physicals, for the purposes of fulfilling the Commonwealth of Virginia's immunization compliance requirements.

ODU COMMUNITY CARE NURSE-LED PATIENT-CENTERED

C-TIER CENTER FOR TELEHEALTH · INNOVATION · EDUCATION · RESEARCH

Old Dominion University Community Care
1881 University Drive, Virginia Beach, VA 23453
oducommunitycare@odu.edu
757-452-2737

Print **the Student's** name: _____ _____
(Last) (First) (MI) (Date of Birth)

☐ **Consent to Treatment:** The purpose of this consent is to obtain permission from the Student's parent or legal guardian for the provision of health care services, including evaluation and treatment by a licensed healthcare provider who may be overseeing a healthcare student. Except in those limited situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent, ODU Community Care must have a written, signed consent from a parent or legal guardian prior to providing health care services to the Student.

By my signature below, I hereby request and authorize that the Student may:

(1) receive health care services available from, and deemed necessary by, ODU Community Care, which services may include, but shall not be limited to, the administration of medication, treatment of acute illnesses and injuries, wellness check-ups, and immunizations;

(2) receive referral care and emergency transportation to other health care providers, as deemed necessary by the ODU Community Care;

(3) I have received a copy of the "Notice of Privacy Practices" from ODU Community Care.

☐ **Consent for Telehealth Services:** Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or specialist. The information may be used for diagnosis, therapy, follow-up, and education. It may include sharing of the patient medical record, medical images, live two-way audio and video and output data from medical devices that include sound and video files.

By my signature below, I hereby request and authorize the ODU Community Care to:

(3) release information related to health care services provided to the Student to the appropriate third-party payor for payment purposes; and

(4) exchange information pertaining to the Student's School Entrance Health Form, and related immunizations and school entrance physicals, for the purposes of fulfilling the Commonwealth of Virginia's immunization compliance requirements.

The above checked consents are authorized for the length of time the Student is enrolled at the Franklin City Public School System. I may choose to withdraw any consents at any time. Any consent withdrawal must be communicated, in writing, to the ODU Community Care. I understand that even if I, as the Student's parent or legal guardian, withdraw consent for the Student to receive health care services at the ODU Community Care, the Student may still seek treatment in those situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent.

Student's Signature _____ Date _____

Parent's/Legal Guardian's Signature _____ Date _____

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