Webb City School District R-7

(417) 673-6010 x276 Fax: (417) 673-6096

School Based Health Clinic: District Consent Form

I give consent for medical treatment by Webb City Schools Mercy clinic to the student named below. If consent is for a minor child, I understand that no treatment will be given without my knowledge, unless it is an emergency.

I assign to Webb City School Mercy clinic any and all benefits payable from any insurance provider covering the patient, which will be applied to the charges for services rendered. I also understand that charges for services that are not covered by insurance are my responsibility. I understand that Webb City School Mercy clinic may disclose any or all of the patient's medical record to any government program, insurance company, corporation or person, which is or may be liable under a contract of Mercy clinic charges.

I authorize Webb City School Mercy clinic to disclose all or any portion of the patient's health record to their medical provider, who is: _____ & preferred pharmacy: _____.

I authorize Webb City School Mercy clinic to disclose all or any portion of the patient's health record to Webb City school staff as it relates to my child's academic success.

I authorize Webb City School Mercy clinic to examine the patient's school health records to assist staff in providing necessary care for my child.

I understand WCR7 may transport to the clinic for care if needed and that I will be notified before student is transported by school employee in school vehicle.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient.

Signature of responsible party

Relationship to patient Date

Student Name:_____ Date of birth:_____

School:_____ Grade: _____