Student/Patient Name:_____ Date of Birth:_____

GREATER VALLEY HEALTH CENTER
Consents and Notices

CONSENT TO HEALTHCARE TREATMENT

The Greater Valley Health Center provides health care services to students at Kalispell School District. Please read this form carefully and provide all the requested information to allow your child to receive health services at school.

1. I give permission for Greater Valley Health Center to provide any of the health and mental health services listed below, except as noted to my child. This includes consent for any of the following, when advised or recommended by the staff of the Greater Valley Health Center and Behavioral Health services will be provided by our partners from Intermountain Deaconess Children's Services.
    - Mental or behavioral health services, including screening, assessment, and counseling/treatment.
    - Diagnosis/treatment of minor and acute illnesses, including first aid for minor injuries.
    - Routine physical examinations, including exams for sports or pre-employment clearance.
    - Immunizations
    - Assistance with chronic illnesses
    - Laboratory services
    - Vision and hearing screenings
    - Over the counter and prescription medications
    - Health and wellness education
    - Referrals for health services which cannot be provided at this clinic.
    - Oral Health

Except I DO NOT want my child to receive the following services from the above list:_____

2. I understand my consent covers only those services directly provided at Kalispell School District. I understand that I can change my mind later and decide I do not want my child to receive services at Greater Valley Health Center. If I change my mind, I will let Greater Valley Health Center know in writing by sending a letter to the following address:

    Greater Valley Health Center
    1035 First Avenue West, Suite 210
    Kalispell, MT 59901

    I understand this consent form remains valid for one year or until the clinic receives a written revocation from me.
3. I understand Greater Valley Health Center will bill for services provided, which includes to private insurers and Medicaid. Any charges not covered by an insurance will be billed directly to the guarantor of the patient on a sliding fee scale based on income eligibility.
4. I understand to be considered for the sliding fee scale (services provided at a reduced rate) I must provide verification of income.
5. I understand by giving consent to being treated by the Greater Valley Health Center via Kalispell School District, I am a patient of Greater Valley Health Center and have patients' rights and responsibilities as any patient being treated through Greater Valley Health Center.
6. I understand that Greater Valley Health Center will retain access to my electronic health record for the purposes of providing integrated care.

BI-DIRECTIONAL INFORMATION SHARING CONSENT

- All healthcare information is confidential. By signing the consent form you are giving the GVHC, "need to know" school staff with health responsibilities, your child's primary care provider (includes medical, dental, vision, and behavioral health if applicable) permission to communicate and share health-related information regarding your child's care on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner.

- Confidentiality between the student, parents, and the health center is assured. By law, some information requires the student's written consent before disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions (GVHC).

CONSENT TO SUBMIT IMMUNIZATION RECORDS

I authorize Greater Valley Health Center to collect and enter my (or my child's) immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand information in the registry may be released to a public health agency as well as healthcare providers to assist in my (or my child's) medical care and treatment. In addition, information may be release to schools to comply with immunization requirements. I understand I can revoke this authorization and have the record removed at any time by contacting my local health department.

Signature of Parent/Guardian/Caregiver:_____ Date:_____

Print Name of Parent/Guardian/Caregiver:_____ Date:_____

ADDITIONAL INFORMATION ABOUT THIS CLINIC

The school-based health center is operated by the Greater Valley Health Center in cooperation with Kalispell School District and Intermountain Deaconess Children's Services. It is not part of, or directly operated by, Kalispell School District.

Under Montana law, youth do not need parental consent to receive certain health care services. Some examples of services youth may obtain on their own are diagnosis and treatment of sexually transmitted diseases and pregnancy related care. If you would like more information regarding these laws and the services we provide, please contact us at, 406-607-4900.