

**MILWAUKEE ACADEMY OF SCIENCE**  
**PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CARE SERVICES**

*Please read this form carefully.*

In an effort to promote the health and well-being of MILWAUKEE ACADEMY OF SCIENCE students, MILWAUKEE ACADEMY OF SCIENCE offers students access to comprehensive health care services at school-based clinics. Such services are provided by qualified nurse practitioners, nursing students, medical students, resident physicians and other health care providers from Aurora Health Care (Aurora Clinic Staff). This consent form describes the services available to your son/daughter at the school-based clinic located at MAS (School Clinic) and other important information.

Your son/daughter may receive the following health care services at the School Clinic:

- Physical examination, health assessments, and screening for health problems.
- Diagnosis and treatment of acute illness and injury (including over-the-counter medications such as acetaminophen (Tylenol), ibuprofen (Motrin or Advil), and cold and cough medications).
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Diagnosis and management of chronic illness.
- Health education and promotion (including smoking cessation, nutrition, and weight management).
- Immunizations and vaccinations.
- Reproductive health care services (including gynecological examinations with PAP smears, pregnancy testing, and family planning services).
- Sexually transmitted disease (STD) education, testing, and treatment (including HIV/AIDS).
- On-going counseling services.
- Dental examination and treatment.
- Referrals to other health care providers and agencies.

Under Wisconsin law, your son/daughter may obtain some of these services without your consent. As a result, Aurora Clinic Staff may provide these services to your son/daughter without contacting you before or after the services are provided. Aurora Clinic Staff will provide these services to your son/daughter if the services are in his/her best interests, and he/she understands and consents to the services. In addition, Aurora Clinic Staff will encourage each student to involve his/her parents in decision-making.

Your son's/daughter's health information may be disclosed and exchanged among Aurora Clinic Staff, MILWAUKEE ACADEMY OF SCIENCE personnel, other health care providers, and/or third party payors (insurance) in order to provide and bill for health care services (except for HIV test results which require a separate consent). In some circumstances, services provided in the School Clinic may be billed to your insurance company.

If you have any questions or concerns about the services offered at the School Clinic, please contact Andrea RN at 933-0302 x5205

**Please complete and return page 2 of this form to school office.**  
**Keep page 1 of this form for your records.**

MILWAUKEE ACADEMY OF SCIENCE  
PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CARE SERVICES

Please return this form to school office.

STUDENT INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Personal/Family Physician: \_\_\_\_\_ Office Telephone #: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Health History: \_\_\_\_\_

Preferred Hospital\*: \_\_\_\_\_

\* In the case of a medical emergency, the Student will be transported to the nearest qualified facility.

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address (if different from Student's): \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address (if different from Student's): \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

EMERGENCY CONTACT(S)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

PARENT/GUARDIAN CONSENT

I have read and understand page 1 of this form. By signing below, I acknowledge that health care services may be provided to my son/daughter at the School Clinic without contacting me. I agree that my son/daughter may consent to receive such services at the School Clinic on his/her own behalf. I hereby authorize Aurora Clinic Staff to provide health care services in the best interests of my son/daughter. I consent to the disclosure and exchange of my son's/daughter's health information among Aurora Clinic Staff, MILWAUKEE ACADEMY OF SCIENCE personnel, other health care providers, and/or third party payors (insurance) in order to provide and bill for health care services. I understand that this consent is valid for the duration of my son's/daughter's enrollment in the school.

**X** \_\_\_\_\_  
Signature of Parent/Guardian Date

TURN OVER

I authorize the Aurora School Based Health Program to bill my insurance company for services provided to my child, \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medicaid information:**  
(T-19, BadgerCare, BadgerCare Plus, Medicaid HMO, Blue Card, Forward Card)

Subscriber Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

**Commercial Insurance:**

Employer Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Insurance Company ID # {or policy #}: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective Date: \_\_\_\_\_