Grade_____

Eagles Nest Consent

Brought to you by Taylor Regional Hospital

Eagles Nest mission is to provide outstanding healthcare to the people we serve. This form is to be completed by the child's parent or legal guardian, to include signature as indicated. Please return the completed form to your child's teacher as soon as possible for the 2023-2024 school year. Upon parent or guardian's request this form may be retracted at any time by contacting the school nurse.

NAME: _____ SEX: M_____ F_____ DATE OF BIRTH ____/____/_____
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____GUARDIAN CELL PHONE: _____

SOCIAL SECURITY #:_____ ETHNICITY: _____ RACE: _____

GUARANTOR INFORMATION:

ARE THERE GUARDIANSHIP ISSUES? : _____YES _____NO IF SO, PLEASE PROVIDE DOCUMENTS

GUARDIAN'S NAME: _____ CELL PHONE: _____ WORK PHONE: _____

MOTHER'S NAME: _____ CELL PHONE: _____ WORK PHONE: _____

FATHER'S NAME: _____ CELL PHONE: _____WORK PHONE: _____

EMERGENCY CONTACT: _____PHONE NUMBER: _____RELATIONSHIP:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SUBSCRIBER NAME: _____

RELATIONSHIP TO SUBSCRIBER: _____

SUBSCRIBER DOB: _____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID: _____ GROUP#:_____

INSURANCE MAILING ADDRESS: _____

SECONDARY INSURANCE: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID: _____ GROUP #:_____

INSURANCE MAILING ADDRESS: _____

CONTINUED ON BACK

Student Name: _____ DOB: _____

MEDICAL HISTORY

Below is a list of conditions that you should answer: C for your child, M for Mother, F for Father, S for sibling, or G for grandparent. Please put the corresponding letter by each listed condition:

__Alcohol/drug addiction
__Alzheimer's
__Anaphylactic reactions
__Anemia
__Arthritis
__Asthma
__Birth defects
__Bleeding disorders
__Blood transfusions
__Cancer
__Chest Pain
__Chicken pox
__Unexplained weight gain/loss
__COPD
__Diabetes
__Ear, nose, throat problems
__Exposed to tuberculosis
__Heart attack/stroke
__High cholesterol
__High cholesterol
__Joint pain or muscle stiffness
__Kidney disease
__Liver disease/hepatitis
__Measles
__Mental illness
__Mumps
__Osteoporosis
__Persistent cough
__Rheumatic fever
__Scarlet Fever
__Shortness of breath
__Sickle Cell
__Sleep problems
__Stomach/ bowel
__Thyroid Disorder
__Tiredness

Date of last Wellness exam/Sports Physical: _____
Where does your child receive their immunizations? _____
Does your child smoke? Y_____ N_____ Is your child exposed to second hand smoke? Y_____ N_____
Does your child consume alcohol? Y _____ N_____

MEDICATION LIST

Please put an "X" next to the listed medication that you do **NOT** want your child given:

__Antibiotic Ointment
__Benadryl
__Claritin
__Cough drops
__Tylenol
__Finger stick blood glucose testing
__Hydrocortisone 1% cream
__Ibuprofen (Motrin)
__Tums
__Orajel
__Sudafed
__Topical antiseptic
__Cough Syrup

Child's Doctor: _____ Child's Dentist: _____

Child's Pharmacy: _____ ALLERGIES: _____

Child's current medications: _____

SURGICAL HISTORY:
Serious Illness/Injuries: _____

Hospitalizations: _____

I, the patient or authorized representative, consent to any examination and treatment regarding illness, injury, wellness or other health concerns affecting me or my child at the time I present to Eagles Nest. These services may include, but are not limited to, laboratory tests, physical examinations, and treatment/procedures. I have read and understand this agreement. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am authorized to act on behalf of the patient and to sign this agreement. I acknowledge that I have received a copy of the Notice Of Privacy Practices (effective September 13, 2013), which explains how my protected health information may be used and disclosed for treatment, payment and health care operations. I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts the assignment. I authorize release of medical information to mine or my child's primary care physician (listed above).
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance claims.
Financial policy: By signing below, I agree that I have read and fully understand the financial policy set forth by TRH Medical offices and I agree to the terms of this policy. I also understand that the terms of this policy may be amended by the practice at any time without prior authorization of the patient.

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE PRINT NAME RELATIONSHIP

_____ _____ _____
EMAIL ADDRESS PHONE NUMBER DATE

NAME:_____ SEX: M____ F_____ DATE OF BIRTH ____/____/_____

LAST FIRST Middle

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ HOME PHONE:_____CELL PHONE:_____

SOCIAL SECURITY #:_____

Primary Care Physician_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID:_____ GROUP#:_____

SECONDARY INSURANCE_____ SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID:_____ GROUP #:_____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims. Financial policy: By signing below, I agree that I have read and fully understand the financial policy set forth by TRH Medical offices and i agree to the terms of this policy. I also understand that the terms of this policy may be amended by the practice at any time without prior authorization to the patient.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE

FLU VACCINE CONSENT

***Parent must be present for students 6 years and younger.**

Patient Name _____ **DOB**_____ **Homeroom**_____

ADDRESS_____CITY:_____

STATE:_____ZIP:_____HOME PHONE:_____CELL: _____

SOCIAL SECURITY #:_____ PRIMARY CARE PHYSICIAN:_____

Are there any guardianship issues? Yes or No. If so, papers must be provided.

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____SUBSCRIBER NAME: _____

SUBSCRIBER DOB:____/____/____SUBSCRIBER SOCIAL SECURITY#:_____

SUBSCRIBER ID:_____GROUP#: _____

Influenza is a highly infectious, serious respiratory illness that kills an average of 79,000 people yearly and hospitalizes more than 960,000 persons in the U.S. each year.

THE SIMPLE FACTS:

- The vaccine has been proven to reduce the risk of acquiring the flu and reduces the risk of flu-related hospitalizations.
- It is biologically impossible to get the flu from the vaccination.

PLEASE ANSWER THE FOLLOWING QUESTIONS	Yes	No
Have you had a severe (life-threatening) allergy to a vaccine in the past?		
Have you had the paralytic illness Guillain-Barre' Syndrome?		
Do you have an allergy to medications/food/vaccine component/latex?		
Are you moderately or severely ill at this time?		

I have been given the opportunity to ask questions and understand by signing below, I am consenting to the administration of the Influenza Vaccine and acknowledge receipt of the Influenza Vaccine VIS (8/6/21) https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims. Financial policy: By signing below, I agree that I have read and fully understand the financial policy set forth by TRH Medical offices and I agree to the terms of this policy. I also understand that the terms of this policy may be amended by the practice at any time without prior authorization to the patient.

_____

Parent/Guardian Signature **Date**

Completed by staff:

Date Time	Manufacturer	Lot#	Expiration Date	Site (Deltoid)	Administered by	VFC or Private
				Left Right		