Innovative Arts Academy
Catasauqua, PA

CONSENT FOR ENROLLMENT IN THE SCHOOL HEALTH PROGRAM

Services through the School Health Program will be provided by Lehigh Valley Hospital (LVH). In order for your child to receive care, you must consent to the treatment of your child by the health care provider offering care at your child's School Health Program. You must also give permission for the School Health Program and Primary Care Provider to share health information about your child. In addition the following information must be filled out.

CHILD'S INFORMATION

Child's Name: ____________________

Child's Date of Birth: ________/________/________
Month Day Year

Date of last physical: ____________________

Sex: ☐ Male ☐ Female Grade ________

Name of School: ____________________

Ethnicity: ☐ Hispanic / Latino ☐ Black ☐ White ☐ American Indian ☐ Asian ☐ Other ________

Child's Primary Care Physician:
Name: ____________________

Telephone: ____________________

Allergies: ____________________

Current Medications: ____________________

Health Concerns (includes current pregnancy): ____________________

PARENT / GUARDIAN INFORMATION

Mother:
Last Name: ____________________
First Name: ____________________

Father:
Last Name: ____________________
First Name: ____________________

Legal Guardian, if applicable:
Last Name: ____________________ First Name: ____________________
Relationship to child: ____________________

Contact Information for Parent or Guardian:
Home Tel: ____________________
Work Tel: ____________________ Ce

Additional Emergency Contact:
Name: ____________________
Relationship to Student: ____________________
Home Tel: ____________________ Work Tel: ____________________
Cell: ____________________

INSURANCE INFORMATION

Insurance Coverage ☐ ☐ No Yes **Insurance Nam**

Policy #: ____________________ **Group #**: ____________________ **Services I don't want my child receive:** ____________________

If the child has no medical insurance, an application must be completed by the parents and submitted to the LV Financial Assistance Program office. If the above process is not completed or you do not qualify for financial assistanc you may receive a bill for services.

PARENTAL CONSENT FOR SCHOOL HEALTH PROGRAM SERVICES

I hereby consent and give permission for my child to be enrolled in the School Health Program and give permission for my child be treated and seen in the School Health Program, which may include school health exam, school mandatory immunizations ar behavioral health assessments. My consent will be valid for the school year 2023-2024 and expires on 6/30/24. If I change n mind and wish to withdraw my permission, I must give the School Health Program a letter telling them I am withdrawi permission. Please call the school nurse with any questions.

Name ____________________ Parent / Guardian (Please Print)
Address ____________________