

**Dr. Joel & Carol Bower School- Based Health Center**  
**Formerly, Basic High School Nevada State College School-Based Health Center**  
**serving students attending Henderson area schools**

Parent/Guardian Consent Form

Nevada State College and the Clark County School District are working together to make health care available to all children at your child's school. Your child may receive health care at the school based health center located in the parking lot at Basic High School, 400 N. Palo Verde Dr., Henderson 89015. Call **799-0508** for more information.

**It is necessary for you to sign this form for your child to receive the following Services:**

1. First aid and minor emergency care.
2. Preventative health exams and special physicals for sports, ROTC, work or college.
3. Treatment of illnesses (stomach aches, earaches, cuts, sores, colds, cough, etc.)
4. Immunizations as required by the Clark County School District for attendance.
5. Blood and urine tests when needed.
6. Health and prevention education.
7. Management of chronic illness, such as asthma and diabetes.
8. Mental health screening and referrals.
9. Dental screening and referrals.
10. Medically necessary prescriptions and over the counter medication.

**The School Based Health Center does not provide sex education or family planning and does not prescribe contraceptives.**

In addition to the school-mandated vaccines, the SBHC offers the following CDC recommended vaccines. Please indicate by initialing each box the vaccines you authorize your child to receive. A vaccine questionnaire is required for your child to receive vaccines and must be signed by a parent or legal guardian. You or your child must stop by the health office at your school or the Dr. Joel and Carol Bower – School Based Health Center to pick up the form.

Influenza (Flu) (Available in the Fall)     Menactra (Meningitis)     Gardasil (HPV) Females only

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

I, \_\_\_\_\_, the parent or legal guardian of  
Parent's name (print)

\_\_\_\_\_, give my consent to have him/her receive  
Child's name (print)

necessary services through Dr. Joel & Carol Bower School-Based Health Center. I give permission for the SBHC to release medical information to other health care providers and to appropriate school personnel. Basic High School students may be treated at the SBHC without a parent present with a referral from the school nurse. I understand that I am welcome to come to my child's appointment. I understand that if my child needs a prescription I may need to go to the School Based Health Center or the designated pharmacy to pick it up.

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian

\*\* All students' visits will be reported to parents except where prohibited by Nevada State Law.

### Additional Child Information

Please fill out the following information so we can better serve your child.

**Allergies** to medication, food or other (please list).

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Child's First Name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last Name \_\_\_\_\_

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

Sex :      Male              Female              School: \_\_\_\_\_      Grade: \_\_\_\_\_

Child's Primary Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Race:    . White Non Hispanic    . Black or African American    . Hispanic  
         . Native American, Alaska Native    . Asian    . Native Hawaiian, Pacific Islander    . Other

Language spoken at home:    . English    . Spanish    . Asian    . Other: \_\_\_\_\_



### Insurance Information

**IMPORTANT: Please attach a copy of your Medicaid, Nevada Check-up or Private Insurance card to the parental consent form. This will assist us in arranging referrals.**

. No Insurance              Name of Insured: \_\_\_\_\_  
. Private Insurance              Insured's Social Security#: \_\_\_\_\_  
. Medicaid                      Name of Insurance: \_\_\_\_\_  
. Nevada Check-up              Policy #: \_\_\_\_\_



### Consent to Release Information to My Insurance Carrier

I authorize the release of medical and related information, reportable communicable disease, and mental health records obtained in the course of diagnosis and treatment to my health insurance company or other third party payer for the purpose of obtaining payment for services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date