HAMILTON COUNTY SCHOOLS | School Health

INDIVIDUALIZED HEALTH PLAN

Student Name	Date of Birth
School	DOESYOUR CHILD HAVE MEDICAID/TENNCARE? (circle one) YES NO
Parent/Guardian Name	TENNCARE ID#
Parent Day Phone	Parent Cell Phone

Medications at School (see Pill Counts page for controlled substances)

Medication	Indication	Dose	Route	Time	Side Effects

Procedures at School (must be recorded on Record of Medical Procedure Form)

Medical Procedure:_____ **Beginning Date:**_____

Directions:_____

_____

_____

The information provided establishes the student's treatment plan, and parental signature provides consent to implement this plan.

Parent's Signature:_____ **Date:** _____

Physician Signature:_____ **Physician phone**:_____

Physician Name or Stamp:_____**Physician Fax:**_____

School Nurse:_____**Phone:**_____**Fax:**_____

This consent covers all eligible health services provided through the school district

Release of Medical Information/Consent for Treatment/Authorization of Medications at School:

1. This authorization allows for the release and exchange of information between HCDE (Hamilton County Department of Education), school staff, contracted and employed school health care providers, third party payers and billing agents. Documents that may be included are: IHP (Individual Health Plan), IEP (Individual Educational Plan), medical records, psychological records, educational reports, and relevant test results. If your child has TennCare or becomes eligible for TennCare coverage in the future and is receiving Medicaid-reimbursable services, HCDE is authorized to seek reimbursement for these services from TennCare.
2. I consent to assessment services by Stellar Therapy Services providers for clinical review of my child's IHP. The purpose of this assessment and clinical review is to ensure quality implementation of the healthcare services your child receives in the school. If your child has TennCare or becomes eligible for TennCare coverage in the future and is receiving Medicaid-reimbursable services, Stellar Therapy Services is authorized to seek reimbursement for these services from TennCare.
3. I request payment(s) of authorized benefits be made on behalf of the insured. I understand and agree that payment(s) may be made directly to the provider that is filing the claims for services rendered. I understand that HCDE is responsible for charges not covered by this assignment. If you do not want to give consent for HCDE to submit Medicaid/TennCare claims, please initial here. _____
4. I have received notice of rights to privacy for personal health information, including HIPAA policies.
5. Medications should be given at home whenever possible. Medications must comply with the Board Medication Policy. Medications and medical assistance may only be administered by the School Nurse or designated and trained non-medical school personnel.