INDIVIDUALIZED STUDENT MEDICAL ORDER

Student Name	Date of Birth: Allergies:
School	Does your child have medicaid/Tenncare? (circle one) YES NO
Parent/Guardian Name	TennCare ID#
Parent/Guardian Day Phone	Parent/Guardian Cell Phone

Medications at School (see Medication Log form 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:____

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The information provided establishes the student's treatment plan and parent/legal guardian signature provides consent to implement this plan.

Parent's/Legal Guardian's Signature:____________________ **Date:**____________

Provider Signature:__________________________ **Date:**____________

Provider Name or Stamp:________________________ **Provider 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 HCS (Hamilton County Schools), school staff, contracted and employed school health care providers, third party payers and billing agents. Documents that may be included are: ISMO (Individualized Student Medical Orders), 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, HCS 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 ISMO. 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 HCS is responsible for charges <u>not</u> covered by this assignment. If you do not want to give consent for HCS 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.

TennCare Kids

Consent to Access Information

Student Name:______________________________ Birth Date: ______________

School District: Hamilton County Schools

By signing this Release form, you allow your child's school, along with the Division of TennCare, your child's health care providers, and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's Individualized Education Program (IEP), Individual Health Plan (IHP), and/or Individualized Family Service Plan (IFSP);
2. Medical and behavioral health records, including this type of information that is contained in your child's educational records; and
3. Education reports, records, or relevant special education evaluation results contained in your child's educational records

The purpose for allowing these records to be shared is so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also allows your child's school to verify whether your child is on TennCare so that the school can receive reimbursement for eligible school-based health services under the Individuals with Disabilities Education Act.

If you sign this release form, you will be giving consent for the records listed above to be released to the local education agency (school district), their billing agent(s), the insured's physician(s), and TennCare representatives as needed.

Note: You are not required to sign this Release form in order for your child to receive services in their IEP, IHP, or IFSP. Those services will still be provided to your child at no cost to you. If you do sign the Release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education in your child's school system. Revoking your consent does not change the school district's responsibility to provide required services to your child at no cost to you.

By signing this form, you are indicating the following:

- ✓ I have received a copy of the Notice of Access to Information.
- ✓ I understand and agree that Hamilton County Schools (name of school district) may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed in the IEP, IHP, or IFSP.
- ✓ I understand and agree that the records and information listed above may be released for the purposes described in this release to the people or organizations identified above.
- ✓ I understand that this release will be valid for as long as my child receives qualifying services or until I revoke my consent.

DATE: ____________________

Signature of Parent/Guardian:____