Hazel Health Consent Form

HISD hazel

Our school is partnering with Hazel Health to provide access to quality health care services for all students. The school health representative can initiate a video visit with a Hazel Health provider while your child is at school. **To ensure your child has access to this service, complete BOTH pages of this form.**

To learn more about Hazel or complete this form online, visit:
my.hazel.co/houstonisd

Month / Day / Year

Child's First Name | Child's Last Name | Child's Birthdate

Parent / Legal Guardian #1 Name | Relationship to Student | ( ) Mobile Phone | Email

Parent / Legal Guardian #2 Name | Relationship to Student | ( ) Mobile Phone | Email

Required Insurance Information

Hazel Health has partnered with your school to cover your cost of services so that **there is no cost to your family.**

Why is insurance information needed if a Hazel visit is at no cost to me? Hazel Health bills insurance for services to ensure that the visit cost is covered by your health plan, and there are no out-of-pocket costs for the family.
Having insurance information also helps Hazel to better coordinate care for your child, such as referrals and prescriptions.
Once a visit is completed, you may receive an explanation of benefits (EOB) in the mail. If you receive an EOB, this is NOT a bill, it is simply a record indicating a visit occurred and was submitted to your insurance. No action is needed.
Your insurance information is always kept confidential and stored securely. By providing your insurance information you are empowering Hazel to continue its mission, ensuring every child is seen, heard and cared for.

What if my child does not have insurance? Any student, regardless of insurance status, can use Hazel Health.
Hazel will review and confirm the student's insurance status when a visit is scheduled or delivered.

For more information about insurance, please see our FAQ's at **www.hazel.co/faq.**

Please provide your child's insurance information:

Insurance Provider / Plan Name | Member ID Number | Group Number (if applicable)

Policy Holder First Name | Policy Holder Last Name | Policy Holder Birthdate | Relationship to Student

☐ **By checking this box, I attest that my child does not have health insurance coverage at this time.**

I have read the Hazel Health Services Authorization and Privacy Policy and: (Please check one box below)

☐ I **GIVE** permission for my child to receive health care services from Hazel Health providers.

☐ I **DO NOT give** permission for my child to receive health care services from Hazel Health providers.

Parent / Legal Guardian / Legal Representative Signature (Required) | Date

PLEASE CONTINUE TO PAGE 2 TO INPUT KNOWN ALLERGIES & OTHER HEALTH INFORMATION

This consent will remain valid unless revoked by the parent / legal guardian / legal representative.

Month / Day / Year

Child's First Name _____ Child's Last Name _____ Child's Birthdate _____

Does your child have any allergies?

☐ YES ☐ NO Medication allergies Please List: _____

☐ YES ☐ NO Food allergies Please List: _____

☐ YES ☐ NO Seasonal/Environmental allergies Please List: _____

Is your child currently taking any medications?

☐ YES ☐ NO Please List: _____

If recommended by Hazel's licensed medical provider, can the following medications (age/weight appropriate) be administered to your child at school?

YES	NO		YES	NO	
☐	☐	Tylenol™ / Acetaminophen (pain, fever)	☐	☐	Cough Syrup (cough)
☐	☐	Advil™ / Motrin™ / Ibuprofen (pain, fever)	☐	☐	Sudafed™ / Phenylephrine (congestion)
☐	☐	Children's Pepto™ / Calcium Carbonate (upset stomach)	☐	☐	Hydrocortisone Cream (inflammation, itch)
☐	☐	Liquid Pepto-Bismol™ / Bismuth Subsalicylate (nausea, indigestion, upset stomach)	☐	☐	Benadryl™ / Diphenhydramine (allergic reaction)
☐	☐	Liquid Antacid / Aluminum Hydroxide / Magnesium Hydroxide, Simethicone (upset stomach)	☐	☐	Zyrtec™ / Cetirizine (allergies, allergic reaction)
☐	☐	Throat Lozenge / Benzocaine / Menthol (cough, sore throat)	☐	☐	Zaditor™ / Ketotifen (allergy eye drops)
			☐	☐	Antibiotic Ointment / Bacitracin / Neomycin / Polymyxin B (cuts, infections)

Has your child ever had any of the following health conditions or health concerns?

YES	NO		YES	NO	
☐	☐	Acid Reflux (Heartburn)	☐	☐	Genetic disorder
☐	☐	ADD/ADHD (Attention Deficit Disorder)	☐	☐	High Blood Pressure
☐	☐	Anxiety	☐	☐	Kidney disease
☐	☐	Asthma	☐	☐	Migraine Headaches
☐	☐	Congenital Heart Defect	☐	☐	Seizure Disorder
☐	☐	Constipation	☐	☐	Sickle Cell Disease
☐	☐	Depression	☐	☐	Surgery: Appendix removed
☐	☐	Developmental Delay	☐	☐	Surgery: Ear Tubes
☐	☐	Diabetes	☐	☐	Surgery: Tonsils removed
☐	☐	Eczema	☐	☐	Other (please explain): _____

Does your child have a primary care doctor?

Hazel uses this information to coordinate with your child's doctor and inform them of any Hazel visit. Providing the fax number will allow Hazel to send a visit summary to your child's doctor.

☐ YES ☐ NO

Child's Doctor _____ Phone _____ Fax _____