Carolina Pediatric Associates
Professional, Personalized Care for newborns,
Children, & Adolescents

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Gaffney Location
1610 N.Limestone St.
Gaffney, SC 29340
Blacksburg Location
301 W. Pine St.
Blacksburg, SC 29702

School-Based Health Clinic
Consent for Treatment

Student Name: _____

Parent/Guardian Name:_____

I give my consent for my child, named above, to receive medical care from the school-based Health Program. Care will be provided in a private manner, and information will not be released without my consent. I allow physicians or designated health professionals to provide necessary and/or advisable treatment for my child and to bill for this service. I understand that my child may receive medical care from providers who are authorized by my child's school.

I authorize the holder of medical or other information about me to release to any other third party responsible for payment such as information needed for decisions of Medicaid or third-party claims.

I acknowledge that I will be responsible for any payments not covered by my health plan, including deductibles. I understand this consent form is valid, until I revoke it.

I received a copy of a "Notice of Privacy Practices" from providers who are authorized by my child's school.

_____ _____

Signature of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

Date