Hawkeye Area Community Action Program/FCHA
Child & Adolescent Health Services Consent Form

Client Name:	Date of Birth: Gender: M or F
Title XIX #: MCO: AGI UHC FFS	Phone:
Address:	

I, _____ give Hawkeye Area Community Action Program
(Print name of parent/guardian)
consent to provide my child with Child & Adolescent Health Services by a Registered Nurse, Registered Dental Hygienist, Registered Dietitian, Social Worker, or other qualified staff.

Child & Adolescent Health Services may include the following:

Education/Anticipatory Guidance
Assistance Getting a Doctor or Dentist
Assistance Getting Insurance
Assistance Linking to Community Resources
Assistance Getting Transportation
Assistance Getting Interpreter Services
Referral and other care coordination services
Capillary blood draws and lead poisoning prevention education
Developmental tests
Hearing Screen
Vision Screen
Preventative oral health services - Dental Screening and Fluoride Varnish Application
Depression Screening

- I understand that records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health and its agents and Title V contractors, Iowa Medicaid Enterprise, Early Childhood Iowa or designee for audit, preventative health services, quality improvement, and other legally authorized purposes.
- I understand that the oral health services that will be received do not take the place of regular dental check ups at a dental office.
- I understand that my demographic information will be entered into CIS, the HACAP database.
- I understand that WIC benefits will not be dependent upon signing this form.
- I received a Notice of Privacy Practices.
- I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian, or client (if of legal age).
- I understand that WIC benefits will not be dependent upon signing this form.

Child's Doctor: _____ Date of Last Visit: ____/____/____
Does this child see this doctor for regular physicals and sick care? Y N
Are this child's immunizations up to date? Y N
Does this child have any known allergies? Y N If Yes, Please list:_____
Was this child born prematurely? Y N If Yes, how many weeks? _____
Has this child received an ASQ-3 screen at their Doctors Office? Y N
Does this child have any known developmental delays or issues? Y N If Yes, please explain: _____
Is this child currently on any medications: Y N If Yes, Please list:_____
Does this child have medical insurance? T19 *hawk-i* Private None
Does this child have dental insurance? T19 *hawk-i* Private None
Family Dentist: _____ Last visit within the last 12 months? Y N

Ethnicity: (circle one)
Hispanic
Not Hispanic

Race: (circle all that apply)
American Indian or Alaska Native
Asian or Asian Indian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Primary race:_____

Number of persons in household _____
Annual Household income _____
Is child on WIC? _____

Clerical Use:
Based on Child Health Income Guidelines
This Family qualifies for:
___ No fee ___ Fee ___ Initials

I consent to the agency's use of email and texting to send me scheduling and child adolescent health services information.
☐ No ☐ Yes Email Address:_____

_____ _____
Signature of Parent, Guardian, or Client of legal age **Date**

_____
Printed Name of Parent

Updated 12/7/2017