

RICHARDSON MEDICAL CENTER SCHOOL-BASED HEALTH CLINIC CONSENT FORM

Student's Name:	Last <input style="width: 80%;" type="text"/>	First <input style="width: 80%;" type="text"/>	Middle Initial <input style="width: 80%;" type="text"/>	ID# (Office use only.) <input style="width: 80%;" type="text"/>
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Student's Address: <input style="width: 95%;" type="text"/>	Zip Code: <input style="width: 95%;" type="text"/>
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Student's Date of Birth: <input style="width: 95%;" type="text"/>	Age: <input style="width: 95%;" type="text"/>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <small>h h</small>	Race: <input style="width: 95%;" type="text"/>
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Student's Social Security Number: <input style="width: 95%;" type="text"/>	School: <input style="width: 95%;" type="text"/>	Student's Grade: <input style="width: 95%;" type="text"/>
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Name of Mother (include maiden name) or Legal Guardian: <input style="width: 95%;" type="text"/>	Home Phone: () <input style="width: 95%;" type="text"/>	Work Phone: () <input style="width: 95%;" type="text"/>	Cell Phone: () <input style="width: 95%;" type="text"/>	Employer: <input style="width: 95%;" type="text"/>
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Name of Father or Legal Guardian: <input style="width: 95%;" type="text"/>	Home Phone: () <input style="width: 95%;" type="text"/>	Work Phone: () <input style="width: 95%;" type="text"/>	Cell Phone: () <input style="width: 95%;" type="text"/>	Employer: <input style="width: 95%;" type="text"/>
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Emergency Contact: <input style="width: 95%;" type="text"/>	Relationship: <input style="width: 95%;" type="text"/>	Phone: () <input style="width: 95%;" type="text"/>
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Student's Primary Care Physician: <input style="width: 95%;" type="text"/>	Phone: () <input style="width: 95%;" type="text"/>
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Student's Dentist: <input style="width: 95%;" type="text"/>	Phone: () <input style="width: 95%;" type="text"/>
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Preferred Pharmacy: <input style="width: 95%;" type="text"/>	Names of siblings enrolled in School-Based Health Center: <input style="width: 95%;" type="text"/>
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Please check the type of health insurance your child has:	<input type="checkbox"/> Medicaid/LaCHIP #:	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> No insurance	Text
	<input type="checkbox"/> Private/Other Insurance Co. Name:	<input style="width: 95%;" type="text"/>		
	Co. Address:	<input style="width: 95%;" type="text"/>		
	Policy #:	Group#:	Effective Date:	<input style="width: 95%;" type="text"/>
	Name of policy holder:	Relationship to student: <input style="width: 95%;" type="text"/>		
	Policy holder date of birth:	Policy holder Social Security #:	<input style="width: 95%;" type="text"/>	
Does your insurance pay for prescriptions? <input type="checkbox"/> No <input type="checkbox"/> Yes				

If your child does not have health insurance, would you like information on no cost health insurance? Yes No

Is your child allergic to any food or medicine? No Yes If yes, list:

List of current medications student is on:

Medication Consent:

The following medications will be administered as per DOCTOR'S/NURSE PRACTITONER'S orders only:

Pain medication: Tylenol Advil Cold and Stuffly nose medication Sudafed Tylenol Sinus Dimetapp Nose Spray (afrin, Neosynephrine) Cough or sore throat medication: Cough Drops Cough Syrup	Sore throat lozenges Allergy Medication: Benadryl Claritin, Clarinex Eye Medication: Eyewash solution Antihistamine drops Antibiotic eye ointment/drops Stomachache medication: Pepto-Bismol Antacid	Emetrol Immodium AD Senakot Phenergan Wound Medication: Betadine Hydrogen Peroxide Antibiotic ointment Mediation for itching: Hydrocortisone ointment Calamine	other medications: Anbesol (toothache) Silvadene ointment Lotrimin AF Albuterol (wheezing) Vaseline Carmex Antibiotic ear dorps Decadron injection Epi-PEN *Generic may be substituted
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I UNDERSTAND THIS STUDENT MAY RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL-BASED HEALTH CLINIC EXCEPT THOSE WHICH I HAVE WRITTEN HERE: