# RICHARDSON MEDICAL CENTER SBHC
# LOUISIANA ENROLLMENT/CONSENT FORM
# FOR SCHOOL-BASED HEALTH CENTERS

| | | | | |
|---|---|---|---|---|
| Student's Name: Last | First | Middle Initial | | ID# (Office use only.) |
| Student's Address (include city): | | | | Zip Code: |
| Student's Date of Birth: | Age: | Sex: ❑ M ❑ F | Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino | |
| Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race | | | | |
| Student's Social Security Number: | School: | | Student's Grade: | |
| Preferred Language: | Parent/Guardian Email: | | Student's Cell Phone: ( ) | |
| Name of Mother (include maiden name) or Legal Guardian: | Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( ) | Employer: |
| Name of Father or Legal Guardian: | Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( ) | Employer: |
| Emergency Contact: | | Relationship: | | Phone: ( ) |
| Emergency Contact: | | Relationship: | | Phone: ( ) |
| Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑ | | | | Phone: ( ) |
| Name of Student's Dentist: Please check if student does not have a Dentist ❑ | | | | Phone: ( ) |
| Preferred Pharmacy: (Name and location) | Names of siblings enrolled in School-Based Health Center: | | | |

**Please check the type of health insurance your child has:**

**Please send a copy of insurance card (front and back) to SBHC.**

❑ Medicaid/Healthy Louisiana #: _____ (check one below)

❑ Aetna Better Health ❑ Amerigroup Real Solutions ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑ United HealthCare Community Plan

❑ Medicaid (dental)#: _____ ❑ No insurance

❑ Private/Other Insurance Co.

Name:_____

Co. Address:_____

Phone #:_____ Policy #:_____ Group#:_____

Effective Date:_____

Name of policy holder:_____ Relationship to student:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ❑ No ❑ Yes

**Office use only.**

**Student's Name:** _____ **2nd Identifier** _____

Does your child have any known allergies to food, medications, insects, etc? Please list.

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

List of current medications student is on with dosage (how much) and how often:

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program, the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

**Confidentiality:** The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between insert name of SBHC and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that insert name of SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at insert phone number of SBHC. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

*Add appropriate language approved by the local school board to reflect the local governance of the center and the relationship between the school board and the health care provider, but negligence or hold harmless language is prohibited.*

**Office use only.**

**Student's Name:** _____ **2nd Identifier** _____

**BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:**

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available)

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that insert name of SBHC or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to insert name of SBHC.

**By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.**

**This consent is effective while the student is enrolled in (insert name of school, school system or sponsoring agency) unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.**

We also understand that the school-based health center is operated by insert name of sponsor and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student (optional) Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

STUDENT NAME: _____ DOB: _____ GRADE: _____

**Student Medical History** *(Please indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

| Y | N | Medical Condition | Y | N | Medical Condition |
|---|---|---|---|---|---|
| | | Abnormal Bleeding | | | Ear Infections |
| | | ADHD/ADD | | | Hearing Loss |
| | | Allergies | | | Speech Problems |
| | | Asthma (Please bring inhaler to clinic) | | | Mental Health Concerns/Depression |
| | | Birth Defect | | | Physical Disability |
| | | Brain/Head Injury | | | Respiratory (Lung Problems) |
| | | Broken Bones | | | Rheumatic (Scarlet) Fever |
| | | Cardiovascular (Heart) Problems | | | Seizures |
| | | High Blood Pressure | | | Sickle Cell Disease |
| | | Dental Disease | | | Vision Problems/Eye Disorders |
| | | Diabetes | | | Staph Infection (Abscess or Boil) |
| | | Eating Problems/Poor appetite | | | Other: |

**Student Surgical & Hospitalization History**

| **Has your child ever had surgery? *(If yes, please specify below)*** ❑ Yes ❑ No | | | | | |
|---|---|---|---|---|---|
| **Y** | **N** | **Surgery** | **Y** | **N** | **Surgery** |
| | | PE Tubes (Tubes in Ears) | | | Adenoidectomy |
| | | Appendectomy | | | Bone or Joint Surgery |
| | | Tonsillectomy | | | Other: |

| **Has your child ever been admitted into a hospital? *(If yes, please specify below)*** ❑ Yes ❑ No | | |
|---|---|---|
| **Hospital** | **Date** | **Reason** |
| | | |

**Family Medical History** *(Which of the following medical conditions apply to you or an immediate family member)*

| Y | N | Condition & Details | Relationship to Student (Mother, Sister, etc.) | Y | N | Condition & Details | Relationship to Student (Mother, Sister, etc.) |
|---|---|---|---|---|---|---|---|
| | | Asthma | | | | Diabetes | |
| | | Cancer | | | | Seizures | |
| | | High Blood Pressure | | | | Sudden death before age 50 | |
| | | Heart Disease/Heart Attack | | | | Sickle Cell | |
| | | Emotional/Mental Health Concerns | | | | Tuberculosis | |
| | | Nervous/Mental Disorder | | | | Other: | |
| | | Other: | | | | Other: | |

Reviewed by: _____ Follow-up planned by: _____

RICHARDSON MEDICAL CENTER SBHC
Acknowledgement and Understanding of the
"Notice of Privacy Practices"

I hereby give consent/permission to (insert the SBHC Name) to use and disclose my child's protected health information for the purposes of treatment, payment and health care operations.

I have received a copy of the (insert SBHC name) "Notice of Privacy Practices," which provides detailed information about how they may use and disclose my child's protected health information. By agreeing to the terms provided therein, I will consent to my child's protected health information being shared with a Health Information Exchange.

I understand that:

- I have a right to request a restriction of how his/her protected health information is used and/or disclosed, but the request must be in writing,
- (Insert name of SBHC) is not required to grant my request, but if the (insert SBHC) does grant the request, it will be binding.

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Student's Name

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Signature of Parent or Legal Guardian Date

# RICHARDSON MEDICAL CENTER SBHC
## Request to Immunize

To: Parents/Guardians of Name of Student
From: Name of SBHC
Subject: Immunizations

We are pleased to assist you in keeping your child healthy by completing immunizations that will be due this school year. Signing this form indicates that you have received the VIS forms and you request the School-Based Health Center give your child CDC recommended vaccines including:

HepA (Hepatitis A)
HPV (Human papillomavirus)
MMR (Measles, mumps, rubella)
Polio
DTaP (Diphtheria, tetanus & acellular pertussis)
HepB (Hepatitis B)
Influenza
Meningococcal
Varicella (chickenpox)
Tdap (Tetanus, diphtheris, & acellular pertussis)

Please answer the questions below by circling "yes" or "no"

| | | |
|---|---|---|
| Has your child ever had the chickenpox disease? | Yes | No |
| Does your child have any allergies to medication, food or vaccine? | Yes | No |
| Has your child had a serious reaction to a vaccine in the past? | Yes | No |
| Has your child had a seizure or a brain problem? | Yes | No |
| Does your child have Cancer, Leukemia, AIDS or any other immune problem? | Yes | No |
| Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? | Yes | No |
| Has the student received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year? | Yes | No |
| Is your child pregnant or a chance she could become pregnant in the next month? | Yes | No |
| Has your child received vaccinations in the past 4 weeks? | Yes | No |

If you have any updated records at home, please send them to school with your child. We will make a copy and return your original.

If you would like the insert name of SBHC to administer vaccines, please sign below. There is no cost to you for this service. Please call the insert name and phone number of provider if you have any questions or concerns.

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Student Name_____ Date of Birth_____

I, (PARENT/GUARDIAN NAME) _____give permission for my child to receive immunizations at the insert name of SBHC. Please sign below as receipt of Vaccine Information Statements.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE