RICHARDSON MEDICAL CENTER SCHOOL-BASED HEALTH CENTER

2023-2024 LOUISIANA ENROLLMENT/CONSENT FORM

Student's Name: Last	First	Middle Initial		ID#
Student's Address:		City	St	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/Student 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:
Name of Student's Optometrist: Please check if student does not have an Eye Doctor ❑				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:

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

❑ No insurance

❑ Private/Other Insurance Co. Name: _____

Insurance 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

Does your insurance pay for immunizations? __ No __Yes

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

Has your child had a physical or well child visit in the last 12 months? ___YES ___NO

Office use only.

Student's Name: _____ 2nd Identifier _____ DOB-_____

The School-Based Health Center can administer the following over the counter/prescription medications under standing orders from the School-Based Health Center Physician. Please circle any medications you DO NOT WANT your child to receive:

Tylenol/Acetaminophen	Mylanta	Benadryl	Orajel (toothache)
Motrin/Ibuprofen	Albuterol HHN	Robitussin	Robitussin DM
Sore Throat Lozenge	Aquaphor	Calamine	Hydrogen Peroxide
Hydrocortisone Cream	Lotrimin Cream	Aleve/Naproxen	Saline Eye Wash
Bactroban/Mupirocin	Silver Sulfadiazine Cream	Claritin	Ear Wax Drops
Azithromycin	Ceftriaxone	Lidocaine	Sudafed PE
Xeopenex HHN	Pepto Bismol	Diflucan	Mucinex
Afrin	Immodium	Visine Drops	Pepcid
Triple Antibiotic Ointment	Betadine	VFC IMMUNIZATIONS	

IMMUNIZATIONS ARE PROVIDED TO THE SBHC BY THE VACCINES FOR CHILDREN PROGRAM. PLEASE NOTIFY THE SBHC IN WRITING BELOW IF THERE ARE IMMUNIZATIONS YOU DO NOT WANT YOUR CHILD TO RECEIVE.

_____

_____

_____

_____

Does your child carry an Epipen for any known allergies? ____Yes ____No
Does your child have any known allergies to FOOD, MEDICATIONS, INSECTS, etc? ___Yes ___No

List of current medications student is on with dosage:

_____

_____

_____

_____

_____

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

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies (Seasonal)			Speech Problems
		Asthma/ Lung problems			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			GYN prob or pregnancy
		Broken Bones			Rheumatic (Scarlet) Fever
		Heart Problems/Murmur			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor appetite			IEP/504 Plan

Office use only.

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

Student Surgical & Hospitalization History

Has your child ever had surgery? ***(If yes, please specify below)*** ❑ Yes ❑ No					
Y	**N**	**Surgery**	**Y**	**N**	**Surgery**
		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**	**Y**	**N**	**Condition & Details**	**Relationship to Student**
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sickle Cell	
		Heart Disease/Heart Attack				Anxiety, Depression, Bipolar, Other	
		Emotional/Mental Health Concerns				Other:	

LAHIE Statement- 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 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 Richardson Medical Center School-Based Health Center and the student's personal medical provider upon referral for

Office use only.

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

medical care. I consent to the exchange of relevant health information between the health center staff and the school nurse program, child welfare and attendance, and special services department as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal. We also understand that the school health center may enter information into my child's LINKS (Louisiana Immunization Network for Kids Statewide) record, which is the state's immunization registry, and the STARLIMS system (Louisiana Department of Health) for lab.

The school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than (1) a health care provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment. My signature on the health center enrollment/consent form gives consent for this sharing of information.

Louisiana Law R.S. 40:1095 allows minors to consent for health care in several situations and the medical provider will use sound professional judgment in those situations, when a student presents themselves to receive services at the SBHC.

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.

Office use only.

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

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 ♦ Telehealth (medical and behavioral) ♦ Comprehensive history and physical examinations ♦ VFC Immunizations ♦ Health screenings ♦ Laboratory/diagnostic testing♦ Acute care for minor illness and injury including medications, if indicated ♦ Behavioral health services ♦ Health education and prevention programs ♦ Case management ♦ Referral and follow-up for emergencies ♦ Referral to specialty care ♦ COVID testing ♦Sports Physicals

Acknowledgements/Understandings and Consent for Services

I understand that:

- We understand that the school health center is operated by Richardson Medical Center and its employees and contractors.
- I have received a copy of the Richardson Medical Center SBHC Notice of Privacy Practices which provided detailed information about how they may use or disclose my child's protected health information. I will consent to my child's protected health information being shared with a HIE.

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 Richardson Medical Center School-Based Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Richardson Medical Center School-Based Health Center.

This consent is effective while the student is enrolled in Richland Parish School System unless the School Based Health Center is notified in writing, that I no longer wish for my child to receive services.

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.

_____ _____

Printed Name of Parent/Legal Guardian/Student **Relationship**

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Student (optional) **Date**

Office use only.

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

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

I hereby give consent/permission to Richardson Medical Center SBHC 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 Richardson Medical Center SBHC "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,
- Richardson Medical Center SBHC is not required to grant my request, but if the Richardson Medical Center SBHC does grant the request, it will be binding.

_____

Student's Name

_____

Signature of Parent or Legal Guardian Date

RICHARDSON MEDICAL CENTER SCHOOL BASED CENTER
BEHAVIORAL/MEDICAL TELEHEALTH CONSENT

Student Name: _____
DOB: _____

1. Telemedicine is the delivery of healthcare services using technology. Your telemedicine providers are listed below. Their areas of specialty are Family Medicine. They may be contacted at 177 Hwy 3048, Rayville, La. The phone number is 318-728-4252. Your telemedicine nurse practitioner's/counselor's role in your care is family medicine. The Nurse Practitioner and Counselor are:

   Evelyn Branch, APRN, NPC
   Maria Thompson, LCSW

2. The SBHC providers have a role in your care and work directly with your Primary Health Care Physician.

3. To obtain follow-up care, or for emergencies, please call 9-1-1, contact your Primary Care Physician, or go to your nearest Emergency room.

4. You may wish to get a copy of your telemedicine medical records, or to send the records to another physician. This is how you can obtain your records: you may contact the clinic at 318-728-4252 for instructions on how to obtain your medical records.

5. You may choose to stop any telemedicine visit or to withdraw your consent to telemedicine services and care at any time.

6. Equipment or technology failure may interfere with your evaluation, treatment, or medical care. If that happens, this is what you should do: contact your Primary Care Physician, or go to your nearest Emergency room.

7. While we use technology and equipment that we believe to be reliable, nothing is failsafe. A failure could cause the following: 1) Your care could be delayed. 2) Poor image resolution may interfere with appropriate medical decision making. 3) Telemedicine network and software security protocols which protect the confidentiality of your medical information could fail, causing your personal information to be inappropriately revealed.

Availability of Counselor:
Therapist is available during school hours only. If an emergency situation arises that requires immediate attention, you agree to call the National Suicide

Office use only.

Student's Name: _____ 2nd Identifier _____ DOB-_____

Prevention Lifeline at 1-800-273-8255, dial 911, or go to the nearest hospital emergency room.

Limits of Confidentiality:

You acknowledge that communication with your counselor through HIPPA compliant website are secure but not all personal emails are protected or encrypted.

Although your counselor has taken substantial steps to ensure the confidentiality and privacy of therapy provided online, Richardson Medical Center School-Based Health Centers cannot guarantee the privacy while a student is in the presence of others at their home.

If your counselor believes you are a danger to, or may become a danger to, yourself or anyone else, she is MANDATED by law to inform others or insist that you be evaluated, in person, by another health care professional.

Technical Requirements:

To participate in online or distance counseling, you will be required to have access to a computer or smart device with internet access. A high-speed internet connection will be necessary for video sessions. Video and email sessions will take place through the HIPPA compliant website. It is understood that when communicating via the Internet or other electronic means, disruptions in service or other technical difficulties will likely occur from time to time. Should a disruption occur during a session, you agree to immediately phone your therapist by phone

YOU AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT DOCUMENTATION ON YOUR OWN COMPUTER AND IN YOUR OWN PHYSICAL LOCATION.

I give my permission for my child _____ to receive telehealth services.

_____ _____

Parent Signature Date

Office use only.

Student's Name: _____ 2nd Identifier _____ DOB-_____

RICHARDSON MEDICAL CENTER SBHC

Acknowledgement and Understanding of the

"Notice of Privacy Practices"

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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,
- Richardson Medical Center SBHC is not required to grant my request, but if the Richardson Medical Center SBHC does grant the request, it will be binding.

_____

Student's Name

_____

Signature of Parent or Legal Guardian Date