LEGACY COMMUNITY HEALTH

Date: _____ Chart #_____

School Based Health Care

(281) 628 2050

School Name: _____ **Grade:** _____ **Current student:** ☐ **Sibling of current student:** ☐

Staff child: ☐

STUDENT INFORMTION

Student Name : *First:* *Last:*	Date of Birth:
Street:	Apt number:
City:	Zip code:
Gender: Male: ☐ Female: ☐	Is the student homeless? Yes: ☐ No: ☐

Race: White: ☐ Black/African American: ☐ American Indian/Alaskan Native: ☐ Asian: ☐ Pacific Islander: ☐

Other: ☐ I do not wish to report: ☐

Ethnicity: Hispanic: ☐ Non-Hispanic : ☐

Is the student currently a patient of Legacy Community Health (Legacy)? Yes: ☐ No: ☐

PARENT INFORMAITON

1.Parent/Guardian Name:	Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
2.Parent/Guardian Name:	Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
Emergency Contact Name:		Phone:	Phone- Alternate:	Relationship to Student:

Parent/ Guardian email:

INSURANCE

Does the student have insurance? Yes: ☐ No: ☐	Type of insurance: Medicaid: ☐ CHIP: ☐ Private: ☐	
If student is uninsured, you may contact Legacy staff to connect you with Legacy's eligibility department to receive assistance for insurance enrollment and/or determining if you qualify for sliding scale fees.	Name of insurance plan:	
	Insurance ID #:	PO Box Address:

Student name: _____ **Date of Birth:** _____ **School:** _____

CONSENT FOR MEDICAL SERVICES

-I am the custodial parent or legal guardian of the minor child named above. I understand that I am not required to attend my child's ***medical*** appointment, but I may, if I choose to do so. I authorize Legacy's nurse practitioner and/or physician to treat my child in my absence and if necessary, an authorized adult may accompany my child to receive medical services. The authorized adult may be a medical assistant, a school nurse, the school principal, a school administrative employee, or an adult named by one of them.

-I understand that I must be present for the initial Therapy appointment and for each Psychiatry appointment.

-I authorize and consent to my child receiving services from Legacy and its affiliated providers. Services may include, but are not limited to:

- Any mandated school health services requested from Legacy.
- Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new school admissions.
- Medically prescribed laboratory tests.
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
- Behavioral health services including counseling, therapy, evaluation, diagnosis, treatment and referrals.
- Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on pregnancy prevention, sexually transmitted infections, and HIV, as age appropriate.
- A child in Texas (defined in the Texas Family Code as less than 18 years of age) can consent for the treatment of a reportable infectious, contagious, or communicable disease (for example only and not limited to: HIV/AIDS, other sexually transmitted diseases, tuberculosis and hepatitis); for treatment related to a pregnancy (other than abortion) and, if the child is a self-pay or Medicaid patient, for prescription contraception/birth control.
- I understand that Legacy is required by state law to report information to the City of Houston Department of Health & Human Services when persons test positive for certain diseases (known as "reportable diseases") including, but not limited to, tuberculosis, HIV/AIDS, and syphilis.

Parent/Guardian Signature: _____ **Date:**_____

DISCLOSURES, RELEASES & AUTHORIZATIONS

-A clinical summary is provided to me following most visits. This summary may be in the form of a letter placed in my child's backpack or delivered through the mail, and/or through a phone call. I understand that some limited information, such as immunization history, may be provided by Legacy to the school and/or local or state health department(s).

-I authorize and direct Legacy to bill on my or my child's behalf and collect payment from any insurance or third party payer that covers the services provided to my child. I understand I may receive a bill for any applicable co-payment or co-insurance amounts. If additional treatment is advised by Legacy providers, a referral will be provided to me at the address and/or phone number of record on this application form.

· I agree to the terms and information above. I am giving this consent of my own free will. -I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

-I acknowledge receiving information regarding Legacy's notice of privacy practices and understand it is available online at www.legacycommunityhealth.org.

Parent/Guardian Signature:_____ **Date:**_____