Teen Health Center, Inc.

Providing free medical and mental health care to Galveston County youth since 1985

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ month / day/ year Sex: ____ Male ____ Female

School: _____ Grade: _____

Ethnicity: __Hispanic __ Black __ White __ American Indian __ Asian/Pacific Islander __ Other _____

Patient Address: _____

Street Address City State Zip Code

Who is the patient's regular doctor?

Name: _____ Telephone: _____

Address: _____

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION

Mother's Last Name: _____ Mother's First Name: _____

Father's Last Name: _____ Father's First Name: _____

Legal Guardian (If Applicable) Relationship to patient: __ Grandparent __ Aunt or Uncle __ Other: _____

Last Name: _____ First Name: _____

Contact Information for Parent or Guardian (*Important!! Please provide as much contact information as possible so we will be able to contact you about your child's health*):

Telephone Home: _____ Work: _____ Cell: _____

Email address: _____

Additional Emergency Contact Name: _____Relationship to Student: _____

Telephone Home: _____ Work: _____ Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

__ No __ Yes: Medicaid ID # _____

Does your child have other insurance?

__ No __ Yes: Name _____

Coverage Number: _____

Does your child have Child Health Insurance Plan?

__ No __ Yes: CHIP # _____

PATIENT MEDICAL HISTORY

Does your child have any allergies to medicine?

__ No __ Yes

If yes, please describe: _____

P.O. Box 925, Galveston, TX 77553 www.teenhealthcenter.org Fax: 409-765-5026

Please state the medication your child receives: _____

_____

_____

Does your child have allergies, sensitivities, or reactions to any substances such as food, mold, pollen, animal dander, dust or insects? No Yes
Does your child have asthma? No Yes
Has your child ever had a seizure? No Yes
Does your child have diabetes? No Yes
Does your child have any known heart condition? No Yes
Has your child ever had to stay overnight in the hospital? No Yes
Has your child ever had surgery? No Yes
Has your child suffered from any trauma or severe injury? No Yes
Has your child had any mental health issues? No Yes
Does your child have any other health problems? No Yes
Please explain any "yes" responses: _____

_____

FAMILY HEALTH AND SOCIAL HISTORY

Has any family member had heart disease before age 50? No Yes
Does any family member have Tuberculosis (TB)? No Yes
Have there been any mental health issues in the family? No Yes
Does any family member smoke tobacco in the home? No Yes

Please explain any "yes" responses: _____

_____

AUTHORIZATION FOR SPECIFIC HEALTH CARE SERVICES

Please complete:

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive services such as: routine physical examinations, weight/fitness program, TB skin test, immunizations, management of minor illnesses and injuries - including laboratory tests and medications, and general health education.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive counseling for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive medications for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals. Parent must be present for child to receive medications.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive reproductive services including family planning, birth control, and condoms.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive counseling and testing for the HIV/AIDS virus.

PARENTAL PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed above. My signature provides permission for my child to receive the services I have circled above from the Teen Health Center. I understand that confidentiality between the patient and the health provider will be ensured in accordance with the law, and that patients will be encouraged to involve their parents or guardians in medical decisions and counseling. Teen Health Center works collaboratively with teaching hospitals and Universities. There may be times when learners (e.g., medical students, residents, graduate students) participate in patient care. The same HIPAA policies apply to these learners and confidentiality will be maintained. I understand that I can change my mind later on and decide I do not want my child to receive services from the Teen Health Center. If I change my mind, I will let the Teen Health Center know in writing. I understand that this permission form remains valid until the Teen Health Center receives a written revocation from me. NOTE: By law, parental consent is not required for urgent/emergent first aid treatment and the provision of services where the health of the patient appears to be endangered. Parental permission is not required for patients who are 18 years or older or for patients who are legally emancipated.

In the event of an emergency situation, I realize it may be necessary for the Teen Health Center, Inc to release my child's health information to the school district (i.e. Texas City or Galveston Independent School District) where my child's clinic is housed. This sharing of information is needed to protect my child's health and safety. I also realize that the Teen Health Center may share information with the school nurse to ensure that my child's vaccines are up to date. Separate authorization is required for sharing additional health information. I understand this information will remain confidential in accordance with federal and state laws.

My signature also indicates that I am aware that my child's health information may be released as indicated above and that I have been given the opportunity to review the Notice of Privacy Practices.

X _____ _____

Signature of Parent/Legal Guardian Date

☐ Check box if you do not want to receive information via email or mail from the Teen Health Center, Inc.

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