DePaul Community Health Centers/Daughters of Charity Health Centers
School Based Health Services Consent Form

Student's Name: Last	First	Middle Initial	ID# (Office use only.)
Student's Address (include city):			Zip Code:
Student's Date of Birth:	**Sex: M ☐ F ☐**	**Preferred Language:**	**Student's Race and Ethnicity:**
Student's Social Security Number.	School:		Student's Grade:
Name of Mother (include maiden name) or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Emergency Contact:		Relationship:	Phone: ( )
Student's Primary Care Physician:	Phone: ( )	Student's Dentist:	Phone: ( )
Preferred Pharmacy (Name, Street and Phone Number)		Known Allergies:	

Please check the type of health insurance your child has:

If possible, please send a copy of insurance card (front and back) to DCHC

- ☐ Medicaid/Bayou Health Plan #:_____(check one below)
  - ☐ Amerigroup Real Solutions LA
  - ☐ AmeriHealth Caritas LA
  - ☐ Aetna
  - ☐ LA Healthcare Connections
  - ☐ United Healthcare Community Plan LA
- ☐ Medicaid (dental) #:_____
- ☐ No Insurance
- ☐ **Private/Other Insurance** **Employer Name**:_____
  Employer Address:_____ **Phone #:**_____
  Policy #:_____ **Group #:**_____ **Effective Date:**_____
  Name of policy holder:_____ **Relationship to Student:**_____
  Policy holder date of birth:_____ **Policy holder Social Security #:**_____

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

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

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

- Primary and preventive health care
- Laboratory/diagnostic testing
- Behavioral health services
- Referral to specialty care
- Comprehensive history and physical examinations
- Acute care for minor illness and injury
- Referral and follow-up for emergencies
- Health education and prevention programs
- Immunizations
- Dental services (where available)
- Health screenings

I, as parent/guardian, understand that I will not be charged for any of the services provided through the health center. I also understand that Daughters of Charity Health Centers (DCHC) or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to DCHC.

I also understand that the school based health services are operated by DCHC and its employees and contractors and not with my child's school.

Confidentiality: 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 DCHC has the right to change this notice at any time. I may obtain a current copy by contacting the Administrative Office.

DCHC Statement: I understand that the DCHC 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. I hereby consent to the disclosure of the DCHC's records into the HIEs.

Printed Name of Parent/Legal Guardian	**Relationship (to student)**
Signature of Parent/Legal Guardian	**Date**
Signature of Student	**Date**
Printed Name of School Health Witness/Verify	Position
Signature of School Health Witness/Verify	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.

Louisiana state law prohibits health centers in schools 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.