

School-Based Health Care

903.455.4458

School Name: _____ Grade: _____
 Current student
 Sibling of current student
 Staff child

STUDENT INFORMATION	Student Name: _____ <i>First: _____ Last: _____</i>		Date of Birth: _____			
	Street: _____		Apt number: _____			
	City: _____		Zip code: _____			
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Is the student homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> I do not wish to report					
	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic					
	Is the student currently a patient of Carevide? <input type="checkbox"/> Yes <input type="checkbox"/> No					
PARENT INFORMATION	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private Insurance Company / Medicaid Plan Name: _____			Family Size: _____ Gross Income: \$ _____ (please circle) wk./mo./yr. <i>Information will be used to determine the student's eligibility for Carevide's sliding fee discount program.</i>		
	Subscriber Name: _____					
	Insurance ID#: _____ Group ID#: _____					
Claims Address: _____ City: _____ St: _____ Zip: _____						
Claims Phone Number: _____						
If student is uninsured, you may contact Carevide's Outreach staff for assistance with insurance enrollment services.						


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 understand, if I am not present during my child's appointment, a representative from Carevide or GSD will contact me prior to, during, and/or after my child's visit.
- I authorize Carevide'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 authorize and consent to my child receiving services from Carevide and its affiliated providers. Services may include, but are not limited to:
 - Any mandated school health services requested from Carevide.
 - 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 and treatment of acute and chronic illness, dispensing and prescribing of medications, contraceptive management, and diagnosis and treatment of STIs.
 - Telehealth services when necessary
 - Dental services, including examination, x-ray, and treatment
 - Behavioral health services including evaluation, diagnosis, treatment and referrals.
 - I understand that Carevide is required by state law to report information to the designated state health department 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, tests results related to quarantine guidelines (i.e. alternative diagnosis and COVID results), and return to school notes, may be provided by Carevide to the school and/or local or state health department(s).
- I authorize and direct Carevide 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, co-insurance, or sliding fee discount program amounts. If additional treatment is advised by Carevide providers, a referral will be provided to me at the address and/or phone number of record on this application form and my signature indicates my permission to authorize the release of information to any referral partners.
- I acknowledge that the Notice of Privacy Practices and the Patients' Rights & Responsibilities have been made available to me at www.carevide.org/forms. I have reviewed and agree to the terms outlined in both documents.
- 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.

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