Dear Parents and Guardians,

We are proud to announce our "New" Health Care services at your school this year. InclusivCare in partnership with the Jefferson Parish School System and L.W. Higgins High School will be providing Medical and Behavioral Health services for all students, faculty, and staff. We look forward to providing services for the convenience of parents and students. Services will include Physical Examinations, Screenings, treatment of common colds, sinusitis, migraine headache management, allergic reactions, first aide management of cuts, bruises and more. The most critical services that will be offered are Behavioral Health Services using Child Psychiatrist and Licensed Clinical Social Workers for a combination of Counseling and Medication Management. The clinic will be open 5 days a week.

With this partnership we are seeking 3 Main Goals:

1. **Keeping Students Healthy and Happy**
2. **Keeping Students in school to avoid being absent**
3. **Supporting parents, guardians, & teachers**

All students must have a consent for treatment on file before any services can be provided. Sickness often comes when we least expect therefore, it is best to return the consent form as soon as possible before an illness strikes. By signing the consent form your child will be eligible for all services.

We will be hosting a parent meeting this Fall and wish to meet you in person. We look forward to supporting 100% of the parents/guardians and 100% of the students and faculty. Please contact us at lwhiggins@inclusivcare.com for more information.

TOGETHER WE WILL MAKE A DIFFERENCE!

Go Hurricanes!

With Warm Regards,

Dr. Shondra Williams, CEO

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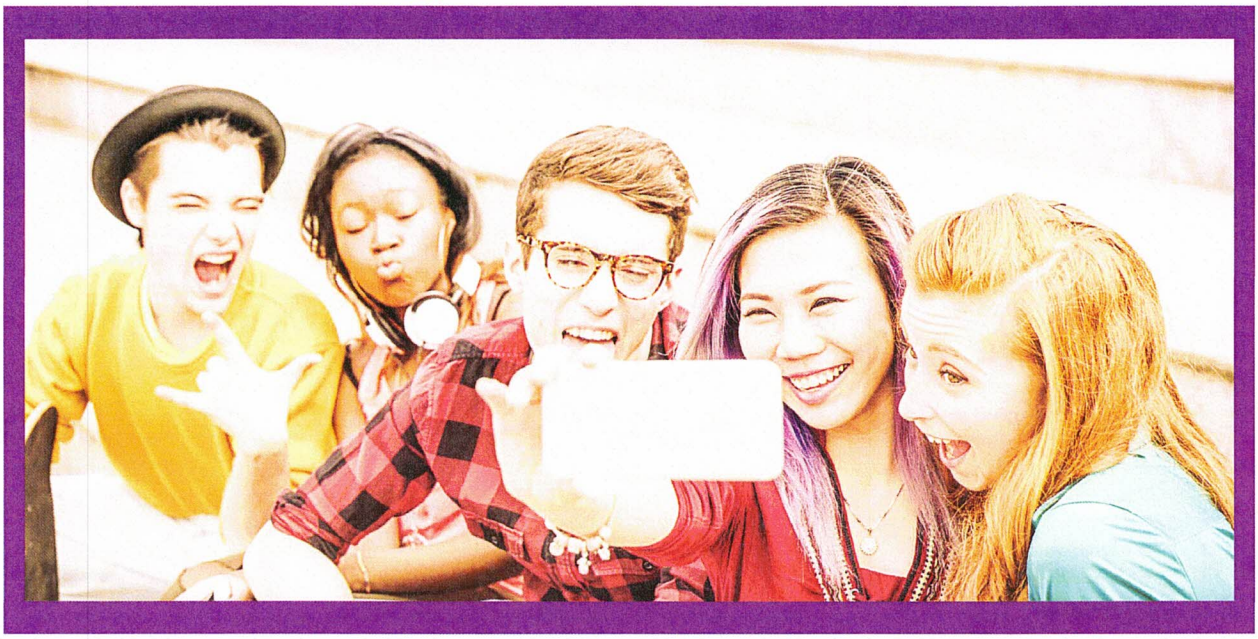
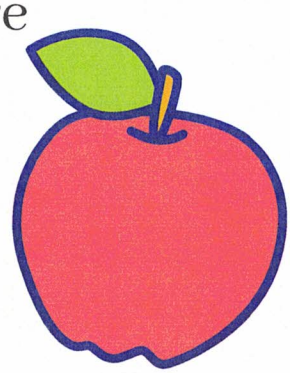
inclusivCare
Healthcare For All.



L.W. Higgins High School
School-based Health Center Services

- Primary and preventive healthcare
- Physical examinations
- Health screenings
- Immunizations
- Laboratory/diagnostic testing
- Management of chronic diseases
- Behavioral health services
- Health education and prevention programs
- Case management
- Referral to specialty care
- Referral and follow-up for emergencies



InclusivCare
Healthcare For All.

L. W. HIGGINS HIGH SCHOOL ENROLLMENT/CONSENT FORM
FOR SCHOOL-BASED HEALTH CENTERS

Student's Name: Last	First	Middle Initial	ID# (Office use only.)
Student's Address (include city):			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: L.W. Higgins High School	Student's Grade:
Preferred Language:	Parent/Guardian 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: ( )

Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:

Please check the type of health insurance your child has:

Please send a copy of insurance card (front and back) to SBHC.

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

❑ Aetna Better Health ❑ Amerigroup Real Solutions ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑ United HealthCare Community Plan

❑ Medicaid (dental)#: _____ ❑ No insurance

❑ Private/Other Insurance Co. Name: _____

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

Office use only.

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

Does your child have any known allergies to food, medications, insects, etc.? Please list.

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

List of current medications student is on with dosage (how much) and how often:

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 hereby consent to the disclosure of the SBHC's records into the HIEs.

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 the School Based Health Centers (SBHCs) and the student's personal medical provider upon referral for medical care. 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 the School Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

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.

NOTE: If you do not consent to these services, your child <u>will</u> still receive limited health services through the School Nurse, including vision and hearing screenings. Your child will not be able to receive OTC medications, physician services, or counseling through the School Based Health Center.

Office use only.

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

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 ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services

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 the Family Service Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the Family Service Center.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in Jefferson Parish School System unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

We also understand that the school-based health center is operated by the Jefferson Parish School System and its employees and contractors.

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

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Student (optional) 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.