CONSENT & ENROLLMENT FORM

School-Based Health Center

SCHOOL: _____ **DATE:** _____

STUDENT'S NAME: _____ **GRADE:** _____

Student's Date of Birth: _____ Student's Sex: _____

Address: _____ City: _____ Zip: _____

PREFERRED LANGUAGE: _____ English _____ Spanish _____ French _____ Other

Race: ___ White ___ Black ____ Asian ____ American Indian ____ Pacific Islander ____ More than one race

ETHNICITY: _____ Hispanic or Latino _____ Non-Hispanic or Latino

EMERGENCY CONTACTS:

Parent/Guardian 1 : _____ Relationship: _____ Phone : _____

Parent/Guardian 2 : _____ Relationship: _____ Phone : _____

Email to Register for Parent Portal Access: _____

INSURANCE: ☐ **Medicaid** ☐ **Commercial Insurance** ☐ **No Insurance**

Insurance/Medicaid Policy ID # _____

*Aetna * Healthy Blue LA * Louisiana Healthcare Connections * United Healthcare * Humana * AmeriHealth Caritas*

Insurance/Medicaid Group # _____ **Phone:** _____

Name of Policy Holder: _____ **Birthdate:** _____ **SSN#**_____

Please attach a copy of your insurance card front and back to this application for School-Based services. Services are provided for students at no out-of-pocket cost to parents. Insurance/Medicaid will be billed.

Pharmacy to send medications to: _____ Phone: _____

Would you like to send your prescriptions through the Access Health Louisiana Pharmacy which offers ***FREE Home Delivery?***
_____ Yes _____ No

Student's Primary Care Provider: _____Phone: _____

Student's Therapist or Psychiatrist: _____Phone: _____

Student's Dental Provider: _____Phone: _____

Do you consent to having **fluoride varnish** applied to your child's teeth during annual well visits to prevent cavities?

_____ Yes _____ No * Information on our oral health program can be found on accesshealthla.org

Do you have access to a smartphone, tablet, or computer? ___ Yes ___ No Do you have WIFI access? __ Yes __ No

Please note: All patient privacy notices, including patient rights & responsibilities and approved over the counter/prescription medications used in our SBHC, are posted on the School-Based health center services page online at accesshealthla.org

Parent/Guardian's Name: _____ **Signature:**_____ **Date:** _____

Student's Name: _____ Date of Birth: _____

MEDICAL HISTORY

PATIENT HISTORY (Please Mark any Item That Applies to Your Child's Medical History)

✔ IF YES	
	ADHD
	ALLERGIES
	ANEMIA
	BIRTH DEFECT
	BLEEDING DISORDERS
	BONE OR JOINT PROBLEMS
	CHICKEN POX (If No, Vaccine Date)

✔ IF YES	
	DEPRESSION
	DIABETES OR PRE-DIABETES
	EAR INFECTION
	HEART MURMUR
	HIGH BLOOD PRESSURE
	KIDNEY PROBLEMS
	MAJOR INJURIES

✔ IF YES	
	HEARING PROBLEM
	VISION PROBLEM
	PREMATURE BIRTH
	SEIZURE
	CHICKEN POX
	ASTHMA
	OTHER

FAMILY HISTORY (Please Mark any Item That Applies to Your Family's Medical History)

✔ IF YES		WHICH RELATIVE
	ASTHMA	
	ALCOHOLISM/DRUG USE	
	ALLERGIES (insects, food, drug, etc.)	
	ANEMIA	
	BLEEDING DISORDERS	
	CANCER	
	DEPRESSION - SUICIDE	
	DIABETES OR PRE-DIABETES	

✔ IF YES		WHICH RELATIVE
	GENETIC DISORDER	
	HEART ATTACK BEFORE 55	
	HEART DISEASE	
	HIGH BLOOD PRESSURE	
	MENTAL HEALTH PROBLEMS	
	SEIZURES	
	TUBERCULOSIS	
	OTHER	

SURGERIES & HOSPITALIZATIONS	✔ IF YES	YEAR/HOSPITAL/TYPE OF SURGURY
Has your child ever been admitted to a hospital for a medical or mental health condition?		
Has your child ever had surgery?		

BEHAVIORAL HEALTH	✔ IF YES	IF YES, PLESE EXPLAIN
Does your child take medication for ADHD, depression or other mental health problems?		
Are there any behavioral health issues or concerns at this time?		
Any special needs that we should be aware of?		

Student's Name: _____ **Date of Birth:** _____

ALLERGIES + MEDICATIONS

STUDENT ALLERGIES

ALLERGY (List medicine or food allergies)	**REACTION**

STUDENT MEDICATIONS

MEDICINE NAME	DOSE STRENGTH	FREQUENCY (How Often)

Policy & Procedure Statement: The SBHC will require a completed consent/enrollment form to enroll a student for services at the SBHC. This complete consent and enrollment form will be good for the student as long as they are attending school within the same school district. The SBHC may ask the parent/legal guardian to complete an annual update form. All minor children, prior to receiving services, must have a current parent consent form on file, with the following exceptions: Patients with a life or limb-threatening emergency or mental health emergency (attempts will be made to contact the parents/guardians at once), patients requesting diagnosis and treatment for sexually-transmitted diseases, HIV counseling, and testing, patients requesting substance abuse services, patients who are legally emancipated, including anyone 18 or older, married, on active duty in the Armed Forces, by court order, or in the presence of a law officer, in which case the parents cannot be promptly located. In all the above cases, the student can be seen one time and for follow-up for the above conditions without consent. Before any other type of care is provided, a signed consent form is required. If a patient requests treatment for an acute medical condition and does not have a signed consent on file, treatment for that illness can be provided for one visit when the parent or guardian is contacted by phone and verbal consent is given, witnessed by two SBHC staff persons over the speakerphone. Verbal consent must be documented in the medical record. If the parent or guardian cannot be contacted, treatment cannot be provided. The student should be referred to their family doctor or emergency room. All parent consent forms remain part of the permanent medical record. Consent forms with questionable signatures may be rejected at the discretion of the SBHC staff. A parent or guardian is defined as either a natural or adoptive parent, in case of divorce, the parent with legal custody, or a non-custodial parent if the other is unavailable. If there is no court order, either parent can consent. Foster parents may give consent for their dependents but must produce a signed document from the natural parents or court. Stepparents, grandparents, and other relatives may not give consent unless they can produce a document showing that they have legal custody. By signing this consent, you are agreeing for the SBHC to provide primary, comprehensive, and preventive healthcare, physical examinations, immunizations, health screenings, laboratory/diagnostic testing, STI testing and follow-up, acute care, management for chronic diseases, behavioral health services, health education, and prevention, case management, referral and follow-ups for emergencies, referral to specialty care, risk assessments, and telehealth services. This SBHC abides by **Louisiana Law R.S. 37:1262** for the utilization of telehealth in the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive technology. I agree to the disclosure of SBHC information to the Office of Public Health, or its agent, in connection with the operation, funding, and ongoing monitoring of SBHCs.

Confidentiality: The SBHCs adhere to all current laws regarding the confidentiality of health services in general and specifically as they relate to services of 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 this SBHC and the student's personal medical provider upon referral for medical care. I may request a copy of the organization's Notice of Privacy Practices that describes how health information is used and shared. I understand that Access Health Louisiana has the right to change this notice at any time. I may obtain a current copy by contacting the SBHC directly or visiting accesshealthla.org online. **Louisiana Law R.S. 40:31.3** states that: Health centers in schools are prohibited from:(1) Counseling or advocating abortion in any way or referring any student to any organization for counseling or advocating abortion. (2) Distributing at any public school any contraceptive or abortifacient drug, device, or other 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.

I, as a legal parent/guardian, understand that I will not be charged for any of the services provided at the SBHC. I also understand that Access Health Louisiana, which operates this SBHC, may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Access Health Louisiana. My signature below acknowledges that I give permission for this student to receive the services provided by the program. This consent is effective while the student is enrolled at a school in this school district unless the SBHC is notified in writing that I no longer wish for the student to receive services. Signature below also acknowledges that I give permission for this student's medication history to be obtained by the medical provider.

____ Check if you consent to your child's photo being used to promote school-based health services on the Access Health Louisiana or school website and/or social media.

_____ _____

Printed Name of Parent/Legal Guardian (or Student over age 18) Relationship to Student

_____ _____

Signature of Parent/Legal Guardian (or Student over age 18) Date