SWLA CENTER FOR HEALTH SERVICES CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS

SCHOOL:_____

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	Race:	Ethnicity:	
Student's Social Security Number:	School:			Student's Grade:	
Preferred Language:	Student's 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: ( )	
Student's Primary Care Physician:				Phone: ( )	
Student's Dentist:				Phone: ( )	
Preferred Pharmacy:	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/Bayou Health Plan #: _____ (check one below)

❑ Amerigroup of LA ❑ AmeriHealth Caritas LA ❑ Aetna

❑ LA Healthcare Connections ❑ United Healthcare of LA

❑ 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

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

Is your child allergic to any food or medicine? ❒ No ❒ Yes If yes, list:

Office use only.

Student's Name: _____ 2nd Identifier

_____

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.**

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above.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.

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

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 (where available) ♦telehealth 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 _____ (insert name of SBHC) or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to _____ (insert name of SBHC).

We (student and parent/guardian) 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.

We also understand that the school-based health center is operated by SWLA Center For Health Services and its employees and contractors.

_____ Relationship: _____

Printed Name of Parent/Legal Guardian

_____ Date: _____

Signature of Parent/Legal Guardian

Effective April 2022