



CommuniHealth services

Dear Parents,

Attached you will find the enrollment packet to register your student with the **School Based Health Center (SBHC)** located on the school campus. The SBHC programs sponsored by CommuniHealth Services are located on the campuses of Riser Middle School, West Monroe High School, Morehouse Elementary School, Bastrop High School, Union Parish High School, and Downsville Community Charter School. The SBHC provides the following services at no cost to the student: sick visits, wellness exams, childhood vaccinations, sports physicals, dental services, and behavioral health/counseling services. Our mobile dental bus will be on site several times throughout the school year to provide preventative dental exams which include cleanings, sealants, x-rays, and fluoride treatments.

All students are eligible to receive services at the SBHC, even if they do not have health insurance. If your student has insurance or Medicaid, we will file the visits on that policy. Any payments made by insurance or Medicaid will be accepted as payment in full. ***No student will be expected to pay for services provided by the SBHC.*** * If your student requires outside services such as labs or x-rays that are performed by a third party you will be responsible for any bill received for services performed by that facility that are not covered by your insurance. If you have any questions, please call your child's SBHC and speak to one of our staff.

BHS SBHC- (318) 239-3883 RMS SBHC- (318) 325-0973
Downsville – (985) 805-6068 WMHS SBHC- (318) 387-8420
MES SBHC- (318) 281-8422 UPHS SBHC- (318) 974-7525

Enrollment is easy, just complete and sign the attached consent form and return it to the school.

No student is treated, counseled, or referred without a consent form completed and signed by a parent. **The last page of the consent packet is a separate dental consent that must also be completed and signed to be seen by Dental staff on our mobile dental unit.**

Any student that returns a signed consent form by September 16, 2022 will go into a drawing for a \$100 Walmart gift card.

The SBHC is truly your partner to keep your student healthy, in school, and ready to learn.

Sincerely,

Kacy Kraft, EPN
SBHC Coordinator

LOUISIANA 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:			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:					Phone: ()																						
Please check if student does not have a Primary Care Provider ☐																											
Name of Student's Dentist:					Phone: ()																						
Please check if student does not have a Dentist ☐																											
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																									
HEALTH HISTORY:																											
Has your child ever been admitted into a hospital or had surgery? Yes _____ No _____ If Yes, Year: _____																											
Reason: _____ Hospital: _____																											
Please mark the item(s) that apply to your child's medical history:																											
<table style="width: 100%;"> <tr> <td>☐ Asthma</td> <td>☐ Nervous/Mental Disorder</td> <td>☐ Endocrine (Diabetes, Thyroid, Pituitary)</td> </tr> <tr> <td>☐ Allergy</td> <td>☐ Heart Disease or Murmur</td> <td>☐ Infectious Disease -Hepatitis, HIV, TB, Meningitis</td> </tr> <tr> <td>☐ Tonsillitis</td> <td>☐ Ear or Sinus Infections</td> <td>☐ Missing Organ (Kidneys, Eyes, Testicles)</td> </tr> <tr> <td>☐ Seizures</td> <td>☐ Hearing or Speech Problems</td> <td>☐ Blood Disorder or Birth Defects</td> </tr> <tr> <td>☐ Kidney Disease</td> <td>☐ Vision problems</td> <td>☐ Genetic Disorder or Birth Defects</td> </tr> <tr> <td>☐ Skin Problems</td> <td>☐ Substance Abuse</td> <td>☐ Major Injuries</td> </tr> <tr> <td>☐ Been Restricted from Sports/PE for Medical Reasons</td> <td></td> <td>☐ Other (specify) _____</td> </tr> </table>							☐ Asthma	☐ Nervous/Mental Disorder	☐ Endocrine (Diabetes, Thyroid, Pituitary)	☐ Allergy	☐ Heart Disease or Murmur	☐ Infectious Disease -Hepatitis, HIV, TB, Meningitis	☐ Tonsillitis	☐ Ear or Sinus Infections	☐ Missing Organ (Kidneys, Eyes, Testicles)	☐ Seizures	☐ Hearing or Speech Problems	☐ Blood Disorder or Birth Defects	☐ Kidney Disease	☐ Vision problems	☐ Genetic Disorder or Birth Defects	☐ Skin Problems	☐ Substance Abuse	☐ Major Injuries	☐ Been Restricted from Sports/PE for Medical Reasons		☐ Other (specify) _____
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Please describe any item marked:																											

Office use only.

Student's Name: _____

2nd Identifier _____

Has your child ever had the Chickenpox? _____

FEMALES: List dates for: First Menstrual Period _____ Last Menstrual Period _____

FAMILY HISTORY:

Please mark the item(s) that apply to your family's history: (brothers, sisters, parents and grandparents)

☐ Asthma	☐ Nervous/Mental Disorder	☐ Endocrine (Diabetes, Thyroid, Pituitary)
☐ Allergy	☐ Heart Disease or Murmur	☐ Infectious Disease -Hepatitis, HIV, TB, Meningitis
☐ Tonsillitis	☐ Ear or Sinus Infections	☐ Missing Organ (Kidneys, Eyes, Testicles)
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☐ Been Restricted from Sports/PE for Medical Reasons	☐ Other (specify) _____	

Please describe any item marked (Who/When):

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:

MEDICATION CONSENT:

The School-Based Health Center will administer medications per the Provider's orders. Over the Counter medications may be administered such as Pain Relievers, Cold medications, Ear drops, Eye drops, Stomach medication (Pepto-Bismol, Mylanta, Midol), Wound medications, Anti-itch medication, and other topical creams/gels for other complaints, such as orajel, carmel, or Vaseline. Prescription medication may be given if found necessary after examination as well. Injections, such as Antibiotic injections or Steroid injection, may be given if deemed necessary by the provider. Nebulizer medications may be administered for asthma type symptoms if necessary for treatment of students.

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER EXCEPT THOSE WHICH I HAVE WRITTEN HERE:

IMMUNIZATION CONSENT (EXCLUDING COVID Vaccine)

Age appropriate Immunizations, including the Flu and HPV vaccines, will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam. **I UNDERSTAND THIS STUDENT MAY RECEIVE ALL IMMUNIZATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER EXCEPT THOSE WHICH I HAVE WRITTEN HERE or checked below:**

I DO NOT WANT MY CHILD TO RECEIVE: (please check below if you **DO NOT** want your child to receive either the FLU or HPV vaccine):

☐ **FLU VACCINE** (Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get flu, but the risk of getting flu is highest among children. Each year thousands of people in the United States die from flu, and many more are hospitalized. This vaccine will help prevent contraction of the flu virus.)

☐ **HPV VACCINE** (This vaccine is recommended for males and females ages 11-26 years of age. HPV is the most common sexually transmitted virus in the United States. This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.)

☐ I do not want my student to receive any of the CDC recommended vaccines.

A separate consent is required for the COVID vaccine. If you wish for your student to receive the COVID vaccine, you will need to call the School Based Health Center and request a COVID consent be sent home for signature.

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. We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Office use only.

Student's Name: _____

2nd Identifier _____

Confidentiality: The School-Based Health Center (SBHC) adheres 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 Center 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.

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 (see pg 2) ◆ 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 provided by either CommuniHealth Services or ULM Dental Hygiene School either on-site or via mobile dental unit ◆ Telemedicine services

*Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables a health care practitioner and a patient at two different locations separated by distance to interact via two-way video and audio transmission simultaneously. Services provided by Telemedicine are provided by CommuniHealth Services employees, contractors, or affiliates and include primary care, behavioral health and specialty 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 School-Based Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to CommuniHealth Services.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided, including the medication consent and Telemedicine services, at the school-based health center. We both give permission for this student to receive the services provided by the program. Regarding the use of telemedicine, the relationship between the treating provider and all other providers involved in my child's care have been thoroughly explained to me and I acknowledge their respective roles in the treatment of my child. Further, I acknowledge my right to withdraw/cease care via telemedicine at any time. **This consent is effective while the student is enrolled in (Ouachita Parish, Morehouse Parish, or Union Parish Schools, as applicable) 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 CommuniHealth Services (formerly Morehouse Community Medical Centers) and its employees and contractors.

Printed Name of Parent/Legal Guardian/Student

Relationship

Signature of Parent/Legal Guardian

Date

Signature of Student (optional)

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.

Office use only.

Student's Name: _____

2nd Identifier _____

Dental Consent Form

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

1. Does your student have a dentist he/she sees routinely? ☐ No ☐ Yes Dentist's name: _____
2. When did your student last have their teeth cleaned? ☐ Not sure ☐ 6 months ago ☐ 12 months ago
3. When did your student last have dental x-rays taken? ☐ Not sure ☐ 6 months ago ☐ 12 months ago
4. How often/when does your student eat sweets, mints, or chew sugar gum? List type: _____
☐ Everyday ☐ once/week ☐ once/month ☐ hardly ever
5. How often/when does your student drink soda or other sweet drinks? _____
6. Is your student having any medical or dental problems, pain or discomfort at this time? If so, please describe.

7. Has your student ever experienced any complications of any kind during dental treatment? ☐ No ☐ Yes
If yes, please explain: _____
8. Is your student allergic to latex? ☐ No ☐ Yes ☐ I don't now

I consent for my child to receive the following dental services:

- dental cleanings – Dental cleanings involve removing plaque (soft, sticky film) and tartar that has built up on the teeth over time, polishing the teeth, x-rays, and fluoride treatment.
- cavity fillings - The dentist will remove the cavity (decayed portion of the tooth) and then "fill" the area on the tooth where the cavity was removed. The filling material can be either white (composite) or silver (amalgam). Most cavity fillings require the tooth to be numbed.
- sealants - A thin protectant material that coats the chewing surfaces of the back teeth to prevent cavities.

from the School Based Health Center dental services provider. Potential complications from these procedures include, but are not limited to, sensitivity, swelling and bleeding of the gums. **Any additional dental services will have a separate consent to be signed at the time the services are provided.** The patient's medical history will be updated at every visit. If your student has a dentist that he/she sees on a regular basis, we encourage you to continue to seek care through that provider. The parent/guardian may be present for all dental visits. If you wish to be present when dental services are provided, you must contact the clinic at the numbers noted below. **I, a parent/guardian, understand that I will not be charged for any of the services provided through the health center.** I also understand the School Based Health Center or the dentist may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the School Based Health Center. I understand that the dental services billed to the student's insurance company may be counted towards any annual benefit limitations. I attest that I am the parent or legal guardian of this student and have legal authority to sign this consent form. If you have any questions, please call (318) 381-0549 or (318) 283-8887 in Bastrop or (318) 325-0973 at Riser SBHC in West Monroe.

Signature of Parent/Guardian

Date

Signature of School Health Staff Witness/Verify

Date

EMERGENCY CONTACT 24/7: CommuniHealth Services (318)283-8887

For Staff Use Only: Copy to parent as applicable _____ Date provided/mail _____