



Salud at Fort Morgan High School Treatment Consent Form

Salud Family Health (Salud) will provide Medical, Behavioral Health and Dental services throughout the school year. Every student can receive services regardless of insurance or ability to pay. If the student does not have any insurance coverage, please call us. We are happy to help you apply for insurances and discounts.

Please fill out the following information to enroll your child for our services. All information provided will be kept confidential.

1. Please enter the information for the student

First Name	Middle initial	Last name
<hr/>		
Preferred Name	Language Preference	
<hr/>		
Mailing Address	City	State
<hr/>		
Zip code	DOB	SSN
<hr/>		
Email Address		
<hr/>		
Preferred Phone		
☐ Home ☐ Cell Phone ☐ Work Phone		
Home Phone	Cell Phone	Work Phone
<hr/>		

2. Please answer the following demographic questions about the student

Sex assigned at birth?
☐ Female ☐ Male ☐ Intersex ☐ Unknown

Are you currently experiencing homelessness?
☐ Yes ☐ No

Do you live in public housing? (Section 8, a Half-way house a Homeless shelter)
☐ Yes ☐ No

What is the student's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ☐ Declined to Specify	if you selected Other, please specify the student's ethnicity <hr/>
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What is the student's race?

- ☐ American indian or Alaska Native ☐ Asian
☐ Native Hawaiian ☐ White ☐ Pacific Islander
☐ Black or African American ☐ Other
☐ Declined to Specify

If you selected Other, please specify the student's race

3. Please enter the information for the student's parent or guardian

First Name

Middle Initial

Last Name

Language Preference

DOB

Mailing Address (If different from patient)

City

State

Zip Code

SSN

Email Address

Preferred Phone

☐ Home ☐ Cell Phone ☐ Work Phone

Home Phone

Cell Phone

Work Phone

4. Salud Family Health receives special funding to provide discounted services to certain patient populations. Please answer the following questions:

At any time in the past two years, have you or anyone in your family had a job working with or transporting plants, trees or farm animals?

☐ Yes ☐ No

If so, to do that work, have you had to establish a temporary home?

☐ Yes ☐ No

At any time did you or anyone in your family retire from a job working with or transporting plants, trees or farm animals?

☐ Yes ☐ No

5. As a Federally Qualified Health Center Salud is required to ask about income levels. This will not affect your eligibility.

What is your estimated household income before taxes?

Frequency income is calculated

☐ Monthly ☐ Annually

Number of financial dependents in your household?

6. Health Insurance Information

My student has coverage

☐ Yes ☐ No

Name of Insurance

Insurance ID/Subscriber Number

Insurance Holder's Name

Group number

7. Preferred Pharmacy Information

Pharmacy Name

City where pharmacy is located

Address

- 8. Disclosure Agreement- Optional** We will share the student's medical information as needed with the person who you designate below. We may call, text or leave voice messages at their specified phone number. We will also answer questions they may contact us with. After reviewing the Notice of Privacy Practice, do you want to designate a family member or other individual with whom we may disclose the student's medical information? I give permission for my student's protected health information to be disclosed for purposes of communicating results, findings and care to the person(s) listed below:

Name

Address

Relationship to the student

Phone number

Specific Notes

- 9. Emergency Contact** Please enter below whom we can contact in the event of an emergency. Please note that this does not grant them access to the student's health information, unless you specify otherwise.

Emergency Contact Name

Relationship

Phone number

Specific Notes

- 10. Electronic Consents** The phone numbers you provided above will be used to message you via text and/or voice about appointment reminders, to reach you about results or telehealth visits. It is your responsibility to maintain your child's information current with us so we may reach you. If you would like to receive communications via alternative means or at alternative locations, please advise a Salud staff member.

Do you want to OPT out of receiving text communications?

☐ Yes ☐ NO

Salud participates in electronic health information exchanges to share the student's health information with other health care providers when relevant to their care, such as hospitals visits. You have the option of opting the student out of this health information exchange if you choose. Do you want to opt out of having the student's health information shared in any health information exchange?

☐ Yes ☐ No

Minor Consents

We need the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). With so many adults working outside the home or with other commitments, we realize that you may not be able to accompany your student on every visit. In that case, please sign the consents at the link below to authorize us to see your minor accompanied by another adult or if your minor is older than 13, to authorize the child to come in unaccompanied.

If you want to authorize care of your student to be accompanied by someone other than a parent or guardian, or to authorize treatment of your student without a parent or guardian present, please print and sign the respective consent below and send it with your student to his/hers/their appointment.

[AUTHORIZATION FOR A MINOR TO BE ACCOMPANIED BY SOMEONE OTHER THAN A PARENT OR GUARDIAN](#)
[AUTHORIZATION FOR TREATMENT OF A MINOR WITHOUT A PARENT OR GUARDIAN PRESENT](#)

11. I give my permission and authorize the student to receive the following services:

- ☐ Medical Services
- ☐ Dental Services
- ☐ Behavioral Health Services

A copy of Salud policies and consents are attached here to and can also be found at saludclinic.org. These documents explain all our policies and how protected health information will be shared or kept confidential.

Signature

Date