WELCOME TO THE ST. MARTIN PARISH SCHOOL-BASED HEALTH CENTERS

Dear Parent/Guardian:

Thank you for choosing to enroll your child in the St. Martin Parish School-Based Health Center (SBHC). We want to welcome your family and give you some information about the SBHC and the services provided. Please keep this letter and refer to it when you need to. If you have any questions, please contact the SBHC Coordinator at (337)909-3040.

The SBHC must have parental consent prior to enrolling a student as a patient. A parent or guardian must sign both the Enrollment/Consent and Privacy Notice contained in this packet. There is also a disclosure for Telehealth services. For a more detailed explanation of our services, please contact your nearest SBHC. Once the parent fills out and signs the packet, the SBHC will provide or refer the student for any of the services that the child needs. Although the SBHC will attempt to keep parents informed of the services their child receives, signing the Enrollment/Consent and Privacy Notice gives the SBHC permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the SBHC**(Please note that immunizations require a separate consent form in addition to this one.)** No child is treated, counseled or referred without a consent form signed by a parent, except in an emergency situation. In emergencies, the SBHC will call the parent, but the SBHC is required by law to treat the child even if the parent cannot be reached. Please note that a consent form may be revoked anytime in writing by a parent/legal guardian.

The SBHC has doctors, nurse practitioners (NPs), nurses (RNs/LPNs) and counselors/social workers who care for students. All of these people are licensed/certified professionals.

Parents do not come out of pocket for any of the services that occur within the SBHC, however, insurance is billed. Please also note that if the SBHC refers the student out to another medical provider for a test or procedure that cannot be done within the SBHC (for example, X-rays, certain laboratory tests, etc.), you may get a bill from that provider.

The services listed in the packet are recommendations/requirements from the American Academy of Pediatrics (AAP) and the Louisiana Department of Health. They recommend these services because they help to prevent illness and keep children healthy.

Please note that this packet is not part of the School Nurse Program. If your child has chronic health needs that need to be addressed at school, please contact your School Nurse.

Please note that we require your signature before your child can be seen in the SBHCs. The signature line is on the last page.

For a more detailed explanation of our services, please contact your nearest SBHC. The contact information for each SBHC is below:

Breaux Bridge SBHC	Cecilia SBHC	St. Martinville SBHC
328 N. Main St.	1021 School St.	762 N. Main St.
Breaux Bridge, LA 70517	Cecilia, LA 70521	St. Martinville, LA 70582
Main Line: 337-909-3040	Main Line: 337-909-3960	Main Line: 337-909-3260
Excuse Line: 337-909-3049	Excuse Line: 337-909-3965	Excuse Line: 337-909-3269

**Please be aware that the packet is now front and back.

Student's Name: _____Date of Birth _____

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ST. MARTIN PARISH SCHOOL-BASED HEALTH CENTERS
2026-2027 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/Student 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:
Student lives with:	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:			

INSURANCE

Please check the type of health insurance your child has:

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

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

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

❑ Aetna Better Health ❑ Healthy Blue ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑Humana Healthy Horizons

❑ **Private/Other**

Insurance Co. Name:_____

Insurance Co. Address:_____

Phone #:_____ Policy #:_____

Group#:_____ _____ Effective Date:_____

Policy holder name:_____ Relationship to student:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ❑ Yes ❑ No

Does your insurance pay for immunizations? ❑ Yes ❑ No

Has your child had a physical or well child visit in the last 12 months?

____yes ____no

Student's Name: _____Date of Birth _____

Student Medical History (*Please fill out completely and indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

Does your child have any known allergies to <u>FOOD, MEDICATIONS, INSECTS</u>, etc? ____ Yes ____ No
If yes, please list below:

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

The School-Based Health Center can administer the following over the counter/prescription medications under standing orders from the School-Based Health Center Physician. Please circle any medications you <u>DO NOT WANT</u> your child to receive:

Tylenol/Acetaminophen	Mylanta/Maalox	Benadryl	Orajel (toothache)
Motrin/Ibuprofen	Albuterol	Robitussin	Robitussin DM
Sore Throat Lozenge	Aquaphor	Calamine	Hydrogen Peroxide
Hydrocortisone Cream	Lotrimin Cream	Aleve/Naproxen	Saline Eye Wash
Bactroban	Silver Sulfadiazine Cream	Claritin	Ear Wax Drops
Azithromycin	Ceftriaxone	Lidocaine	Children's Pepto
Afrin/Neo-Synephrine nasal spray	Allergy Eye Drops		

***Generic forms may be substituted**

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Hearing Loss
		ADHD/ADD			Speech Problems
		Allergies (Seasonal)			Mental Health Concerns-Depression
		Asthma			Mental Health Concerns-Anxiety
		Autism Spectrum Disorder			Mental Health Concerns-Other_____
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Ear Infections			Staph Infection (Abscess or Boil)
		Diabetes			Other:
		Eating Problems/Poor appetite			Other:

Student Surgical & Hospitalization History

Student's Name: _____Date of Birth _____

Has your child ever had surgery? *(If yes, please specify below)* ❑ Yes ❑ No					
Y	**N**	**Surgery**	**Y**	**N**	**Surgery**
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Has your child ever been admitted into a hospital? *(If yes, please specify below)* ❑ Yes ❑ No		
Hospital	**Date**	**Reason**

Student Birth & Developmental History

Was child born full term? _____ Premature? _____ Any problems during pregnancy? _____

Type of delivery? Vaginal_____ C-Section_____ Child's Birth Weight? _____ Child's Birth Length? _____

Did your child have any of the following problems after birth (circle if yes):

Jaundice Convulsions Bleeding Trouble Breathing
Feeding Problems Special Formula Excessive Vomiting Other_____

When did your child crawl? _____sit alone? _____stand without help? _____walk? _____

Is your child toilet trained? Yes_____ No_____ If yes, at what age? _____

Where has your child received his/her immunizations in the past? _____

Family Medical History *(Which of the following medical conditions apply to you or an immediate family member)*

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder: Anxiety, Depression, Bipolar D/O, other				Other:	
		Other:				Other:	

Declaration of Practices and Procedures(Licensed Professional Counselors)

Qualifications

Effective Date: July 1, 2026

Student's Name: _____Date of Birth _____

Adrienne Huval earned a Master of Science from the University of LA at Lafayette in 2005. She is a Licensed Professional Counselor #3809. She has Appraisal Privileges and is also an Ancillary Certified School Counselor with the LA Department of Education, as well as, a Nationally Certified Counselor and Certified Rehabilitation Counselor.

Daisy Auzenne earned a Master of Science in Clinical Mental Health Counseling from Walden University in 2020 . She is a Licensed Professional Counselor # 8311.

Jessica F. Johnson earned a Master of Science in Counselor Education from the University of LA at Lafayette in 2008. She is a Licensed Professional Counselor #4417.

Jessica Cravins earned a Master of Science in Mental Health Counseling from Southern University in 2016. She is a Licensed Professional Counselor #7190.

Tammy Cormier earned a Master of Science in Mental Health Counseling from Walden University in 2014. She is a Licensed Professional Counselor #6081.

We are registered with the LPC Board of Examiners, which is located at 11410 Lake Sherwood Ave. North Suite A, Baton Rouge, LA 70816 (phone 225-295-8444).

The Counseling Relationship
I see counseling as a process in which you, the client, and I, the Counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals. Through this collaborative effort, we will work to explore and define present problems with client situations, develop future goals, personally and emotionally, and achieve success and personal fulfillment.

Areas of Expertise
I focus on clients within a school-based setting and see students from Pre-K to 12th grade. Students may be referred by self, parents, school, or juvenile court system.

Tele-Mental Health Services
Tele-mental health services may not be appropriate for everyone. After a discussion between us, it will be determined if you meet the criteria for Tele-Mental Health Services. A tele-mental health session involves the transfer of information; therefore, it needs to be done in such a way as to maintain the privacy and security of that information. Collecting the information privately means conducting the session in such a way that no one who isn't supposed to be involved in the service can see or hear the consultation. It is incumbent on the person receiving the services to maintain and insure their own confidentially, as well. Sending the information securely means that only those who have a right to access it by being directly involved in the care of the person receiving the services are able to have access.
I, the mental health professional:

- will take steps to ensure that quality of communication during a telehealth encounter is maximized. Any significant technical deficiencies should be noted in the documentation of the consultation.
- will be familiar with the technology in use.
- am aware of and acknowledge the limitations of video/audio in the provision of telehealth health care services.
- have received education/orientation in telehealth communication skills prior to the initial telehealth encounter.
- will strive to determine, to the best of my ability, the appropriateness for, and level of comfort with, telehealth for each individual prior to or at the initial encounter, while recognizing that this will not be possible in all situations.
- to the extent possible, will ensure that the client receives sufficient education/orientation to the telehealth process and communication issues prior to their initial telehealth encounter.

We will discuss and establish a 'crisis plan' when you begin Tele-Mental Health Services.

Fee Scale
There is no charge to the students for services provided.

Student's Name: _____Date of Birth _____

Services Offered and Clients Served
I approach counseling from a cognitive-behavioral perspective in that patterns of thought and actions are explored in order to better understand the clients' problems and to develop solutions. Play, person-centered therapy, and brief solution-focused therapy are also utilized. I work with the clients in a variety of formats, including individually, as a family, and as groups.

Code of Conduct
As a Counselor, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available to you upon request**.**

Privileged Communication
Material revealed in counseling will remain strictly confidential except for material shared under the following circumstances in accordance with state law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, 3) There is reasonable suspicion of abuse/neglect against a child, elderly person (60 or older), or a dependent adult, or 4) A court order is received directing the disclosure of information.
It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures conceivable.

Emergency Situations
If an emergency situation should arise, you may seek help through hospital facilities or by calling 911.

Client Responsibilities
You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate services to you.

Physical Health
Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so and to list any medications that you are now taking.

Potential Counseling Risk
The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

I have read and understand the above information in this Declaration of Practices and Procedures of the Counselors with the St. Martin Parish School-Based Health Centers and my signature below indicates my full informed consent to services provided.

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TELEHEALTH DISCLOSURE

Effective Date: July 1, 2026

Student's Name: _____Date of Birth _____

1. Telemedicine is the delivery of healthcare services using technology. Your telemedicine providers are listed below. Their areas of specialty are Family Medicine or Pediatrics. They may be contacted at 328 N. Main Street, Breaux Bridge, LA 70517. The phone number is (337)909-3040. Your telemedicine physician's/nurse practitioner's/counselor's role in your care is family medicine and pediatrics. The Nurse Practitioners and Counselors are:
    a. Christy Crovetto, APRN, Pediatrics. License number AP06081; 762 N. Main Street, St. Martinville, LA 70582. The phone number is (337)909-3260
    b. Tiffany Jones, APRN, Family Practice. License number AP227157; 328 N. Main Street, Breaux Bridge, LA 70517. The phone number is (337)909-3040
    c. Alexandra Guidry, APRN-CNP, Family Practice. License number AP230691; 1021 School Street, Cecilia, LA 70521. The phone number is (337)909-3960
    d. Adrienne Huval, LPC-SA. License number 3809; 328 N. Main Street, Breaux Bridge, LA 70517. The phone number is (337)909-3040
    e. Daisy Auzenne, LPC. License number 8311;762 N. Main Street, St. Martinville, LA 70582. The phone number is (337)909-3260
    f. Jessica Johnson, LPC-A. License number 4417; 328 N. Main Street, Breaux Bridge, LA 70517. The phone number is (337)909-3040
    g. Jessica Cravins, LPC-A. License number 7190; 328 N. Main Street, Breaux Bridge, LA 70517. The phone number is (337)909-3040
    h. Tammy Cormier, LPC. License number 6081;720 N. Main Street, St. Martinville, LA 70582. The phone number is (337)909-3260

2. Upper St. Martin Parish: Your local health care facility is St. Martin Hospital located at 210 Champagne Blvd., Breaux Bridge, LA 70517. The phone number is (337)332-2178. The local health care provider's role in your care is to follow-up and/or assist with emergencies. You may also follow-up with your child's own Primary Care Provider.
   Lower St. Martin Parish: Your local health care provider is Morgan City Pediatric Clinic at 1234 David Dr., Morgan City, LA 70380. The phone number is (985)384-2430. The local physician/health care provider's role in your care is to follow-up and/or assist with emergencies. You may also access the Teche Regional Medical Center at 1125 Marguerite Street, Morgan City, LA 70380. The phone number is (985)384-2200 or follow-up with your child's own Primary Care Provider.

3. There are the other physicians/health care providers that may have a role in your care: staff members of the St. Martin Parish School Board and their contractors.

4. To obtain follow-up care, or for emergencies, please call 9-1-1, contact your Primary Care Physician, or go to your nearest Emergency room.

5. You may wish to get a copy of your telemedicine medical records, or to send the records to another physician. This is how you can obtain your records: you may contact Adrienne Huval at (337)909-3040 for instructions on how to obtain your medical records. This information may also be found in the Notice of Privacy Practices found on the St. Martin Parish Schools website under School-Based Health Centers and in the St. Martin Parish Student Handbook. You also received a copy with the health center consent form.

6. You may choose to stop any telemedicine visit or to withdraw your consent to telemedicine services and care at any time.

7. Telemedicine is the delivery of healthcare services using technology. Equipment or technology failure may interfere with your evaluation, treatment, or medical care. If that happens, this is what you should do: contact your Primary Care Physician, or go to your nearest Emergency room.
   While we use technology and equipment that we believe to be reliable, nothing is failsafe. A failure could cause the following: 1) Your care could be delayed. 2) Poor image resolution may interfere with

appropriate medical decision making. 3) Telemedicine network and software security protocols which protect the confidentiality of your medical information could fail, causing your personal information to be inappropriately revealed.

8. Our Notice of Privacy Practices can be found in the St. Martin Parish Student Handbook. It can also be viewed on the school district website under School-Based Health Centers. Please read it carefully.

Policies and procedures followed by your Licensed Behavioral Health Professional and the St. Martin Parish School-Based Health Centers. You will be expected to complete the St. Martin Parish School-Based Health Center consent form/ intake form prior to the start of counseling to determine the feasibility and efficacy of receiving online/distance counseling. The intake, among other things, will require that you provide the name and phone number of your physician and a relative or friend to contact in case of emergency. You must also provide documentation of your identity in the form of a School ID, Driver's License, Identification Card, or Passport

Types of Services Provided by Your Therapist:
The St. Martin Parish School-Based Health Centers offer traditional in-office, face-to-face counseling and, **under certain circumstances,** online and/or distance therapy formats.

Availability of Counselor:
Any communications received after hours, on weekends, holidays, or during previously scheduled vacation times will be responded to the next business day, unless other arrangements are made. If an emergency situation arises that requires immediate attention, you agree to call the National Suicide Prevention Lifeline at 1-800-273-TALK(8255), dial 911, or go to the nearest hospital emergency room.

Limits of Confidentiality:
You acknowledge that communication with your counselor (e.g. emails, chats, or video sessions) via the G Suite and/or LGH Anywhere, https://lghanywhere.com/landing.htm, powered through American Well website are encrypted and that emails sent from or to personal email accounts are not secure. You further acknowledge and agree that all communication of a clinical nature should be sent through the G Suite or LGH Anywhere platform, with the exception of Gmail. Gmail is not encrypted. You acknowledge that you will not send your child's PHI through email.

A reasonable attempt will be made to read and respond to the emails received via that site within 24 to 48 hours. You understand that your therapist will not respond to personal and clinical concerns via regular email or texting. Regular email should not be used in the event of a crisis or emergency.

As a rule, personal and clinical communications (i.e. communication for purposes other than scheduling) should be reserved for scheduled session times (in-person sessions, video sessions, email sessions, or phone sessions) except in cases of emergency. You further acknowledge that if either you or your counselor use a cell phone that the conversation may not be secure and therefore not confidential.

Although your counselor has taken substantial steps to ensure the confidentiality and privacy of therapy provided online, St. Martin Parish School-Based Health Centers cannot guarantee the security of any internet or cell phone transmissions or communications.

YOU AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT DOCUMENTATION ON YOUR OWN COMPUTER AND IN YOUR OWN PHYSICAL LOCATION.
If your counselor believes you are a danger to, or may become a danger to, yourself or anyone else, S/he is MANDATED by law to inform others or insist that you be evaluated, in person, by another health care professional. Please see the St. Martin Parish School-Based Health Centers *Informed Consent & Release of Liability and Notice of Privacy Practices* form for additional information regarding limits to confidentiality.

Technical Requirements:

Student's Name: _____Date of Birth _____

To participate in online or distance counseling, you will be required to have access to a computer or smart device with internet access. A high speed internet connection will be necessary for video sessions. Video and email sessions will take place through the HIPPA compliant Google Meets in the G-Suite. It is understood that when communicating via the Internet or other electronic means, disruptions in service or other technical difficulties will likely occur from time to time. Should a disruption occur during a session, you agree to immediately phone your therapist by phone. Each site has a different number. Please see below:

Breaux Bridge Counselor (337)909-3043
Cecilia Counselor (337)909-3962
St. Martinville Counselor (337)909-3265

Other Resources:

Your counselor may refer you to and/or expect you to avail yourself of outside supportive resources, including, but not limited to, other health care professionals, as deemed appropriate. A failure on your part to comply with such recommendations may result in a termination of therapy. It is acknowledged that online or distance counseling is not a substitute for medication given under the care of a psychiatrist or doctor. It is further understood that online or distance counseling is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts.

Payment for Services:

There is no charge to the students who seek counseling services from the school based health center.
I, agree and attest to the following:
1. Student resides in the state of Louisiana.
2. Their counselor is licensed in the State of Louisiana, USA and follows the laws and professional regulations of the State of Louisiana, USA.
3. I have read, understood, and signed the HIPAA notice available on the St. Martin Parish School-Based Health Center consent stating that I have read and understand the Notice of Privacy Practices. The Notice of Privacy Practices can be found in the St. Martin Parish Student Handbook. It can also be viewed on the school district website under School-Based Health Centers.
4. I agree to participate in online/distance counseling. I have read, understood, and will comply with the policies listed above.
5. I am the parent/guardian of the student.

THE REST OF THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK.

Student's Name: _____Date of Birth _____

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 St. Martin Parish School-Based Health Centers 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 St. Martin Parish School-Based Health Centers have the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center or their website. My signature on this consent constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

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 a program, the SBHC is required to provide information to OPH, including but not limited to, PHI/ePHI. Therefore, we consent to the disclosure of SBHC information and PHI/ePHI 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.

All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA), and any/all state/federal laws.. I consent to the exchange of relevant health information between St. Martin Parish School-Based Health Centers (SBHC'S), and the student's personal physician 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 St. Martin School-Based Health Centers have the right to change this notice at any time. I may obtain a current copy by contacting the Health Center Coordinator. My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices. (This can be found in the St. Martin Parish Student Handbook or given as a separate packet along with the consent).

I understand that my health information is stored in a unified electronic medical record system (Greenway Health and Clinical Fusion) owned and operated by the St. Martin Parish School-Based Health Centers which is sponsored by the St. Martin Parish School District. My signature on the health center enrollment/consent form gives consent for this sharing of information. The Notice of Privacy Practices describes how my health information may be used or disclosed by the St. Martin Parish School-Based Health Centers. The Notice is in the St. Martin Parish Student Handbook, website, and/or given with the consent of the student's school. I understand that I should read it carefully and I am aware that the Notice may be changed at any time.

I consent to the exchange of relevant health information (including information about physical exams, health histories, non-imminent threats, and other information) between the health center staff and the school nurses, the district threat assessment team, Pre-K, child welfare and attendance, special services department, athletic trainers/coaches, CCRC Nursing Professor, and the Superintendent as needed in order to facilitate evaluation of this student's health needs, treatment, special education multidisciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding communicable diseases, crises, or threats of grave or serious harm to self or others will be shared with the school for the safety of the student and entire campus.

We also understand that the school health center may enter information into my child's LINKS (Louisiana Immunization Network for Kids Statewide) record, which is the state's immunization registry. Louisiana Revised Statutes 17:170 Sec E allows for you to refuse immunizations for medical contraindication, religious objection, or parental objection, however, you must sign a form of written dissent. Every school has these forms.

Student's Name: _____Date of Birth _____

The school board and the school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than (1) a health care provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment and their auditors/business associates; (3) the spouse, parent/guardian of the minor student; or (4) other situations listed above and in the Notice of Privacy Practices. Although nothing herein contained may prohibit the treatment by a licensed physician/provider of someone in a true emergency situation within the meaning of LA R.S. 40:1159.5, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained in such an emergency may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate consent given on the Attachment.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment.

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 ♦Telehealth Services ♦comprehensive history and physical examinations ♦immunizations(a separate, additional consent form is required for this service) ♦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, including fluoride treatments (where available)

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Student's Name: _____Date of Birth _____

Acknowledgements/Understandings and Consent for Services

"Notice of Privacy Practices" I hereby give consent/permission to St. Martin Parish School-Based Health Centers to use and disclose my child's protected health information for the purposes of treatment, payment and health care operations.

I have received a copy of the St. Martin Parish School-Based Health Centers "Notice of Privacy Practices" located in the St. Martin Parish Student Handbook, which provides detailed information about how they may use and disclose my child's protected health information. This Notice is also posted on the district website and may change at any time. The most current notice can be found at https://www.saintmartinschools.org/departments/schoolhealth-clone. By agreeing to the terms provided therein and signing this document, I will consent to the terms of the Notice of Privacy Practices including my child's protected health information being shared with a Health Information Exchange.

I understand that:

- I have a right to request a restriction of how his/her protected health information is used and/or disclosed, but the request must be in writing,
- St. Martin Parish School-Based Health Centers is not required to grant my request, but if the St. Martin Parish School-Based Health Centers does grant the request, it will be binding.
- We understand that the school health center is operated by St. Martin Parish School District and its employees and contractors.
- We also understand that students with no health center on their campus may be transported by school bus to the health center from their school. School buses transporting students to and from school to the health center shall not carry emergency medications. In the event an emergency arises, the bus driver shall pull over and dial 911 as per emergency protocol.

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 St. Martin Parish School-Based Health Centers or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to St. Martin Parish School-Based Health Centers**.**
By signing this consent, 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 St. Martin 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.

_____ _____
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