SWLA CENTER FOR HEALTH SERVICES CONSENT FORM
SCHOOL-BASED HEALTH CENTERS & MOBILE DENTAL CLINIC

School/Mobile Unit Site: _____

Student's Name: _____ DOB: _____ Age: _____
Last First Middle

Student's Social Security Number: _____ Race: _____ Ethnicity: _____

Sex: ☐ M ☐ F Student's Address: _____
Street City State Zip

School: _____ Grade: _____ Student's Email: _____

Student's Cell Phone Number: _____ Preferred Language: _____

Name of Mother or Legal Guardian: _____
Last First Maiden

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Father or Legal Guardian: _____
Last First

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Student's Primary Care Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Preferred Pharmacy: _____ Known allergies to food or medicine: _____

Please list all the student's current medications with dosage and how often the medication is taken:

_____

_____

Insurance Section – Please upload a copy of the front and back of your insurance card.

Medicaid/Healthy Louisiana (Select One)

☐ Aetna Better Health

☐ AmeriHealth Caritas Louisiana

☐ Louisiana Healthcare Connections

☐ Healthy Blue

☐ Humana Healthy Horizons

Plan Number: _____

Private/Other Medical Insurance

Medical Insurance Company: _____ Policy Number: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Relationship to Student: _____ Group Number: _____
Does your insurance pay for prescriptions? ☐ Yes ☐ No

No Health Insurance
Would you like information on health insurance options? Some plans have no out-of-pocket costs if you qualify. ☐ Yes ☐ No

☐Private/Other Dental Insurance
Dental Insurance Company: _____ Policy Number: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Relationship to Student: _____ Group Number: _____

Has your child seen a dentist before? ☐ YES, in the past year ☐ YES, more than 1 year ago ☐ Never

Dental concerns for your child: _____

Upload a copy of the front and back of your insurance cards here:

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.

Consent Withdrawal Notification: 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-based health center or mobile dental clinic to provide the following services to your child:

- primary and preventative 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 (preventative, restorative, extractions, or emergency care, telehealth services

Please initial the following:

___ I am interested in my child receiving dental services.
___ I understand that I may be present for dental treatment on my minor child and my child's medical history is up-to-date and has been updated within the past six months.
___ I, as parent/guardian, understand that if my child already has a dentist, I can continue to arrange dental care through that provider. I have been given the address and contact information for SWLA Center for Health Services.
___ I give consent for my minor child to receive the following dental services:

- preventative treatment
- dental screenings & exams
- prophylaxis (cleanings)
- radiographs
- fluoride
- sealants
- silver diamine fluoride

I do not consent for my child to receive the following services through the school-based health center (please type services in the space provided, if any):

_____

As parent/guardian, I understand that I will not be charged any out-of-pocket fees for any of the services provided at the school-based health center. I also understand that SWLA Center for Health Services or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to SWLA Center for Health Services.

I have read and understand the services to be provided at the school-based health center. I give permission for the student to receive the services provided by the program. I further understand that treatment through the SWLA Center for Health Services mobile dental clinic may affect the patient's future Medicaid and insurance benefits for up to one year.

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

Printed Parent/Guardian Name: _____ Relationship: _____

Signature of Parent/Guardian: _____ Date: _____

MEDICAL HISTORY

Please place an X next to each condition that YOUR CHILD has now or has previously had:

____ADD or ADHD	____Depression	____Mononucleosis
____Anemia	____Developmental/behavioral disorders	____Muscle/joint/bone problems
____Asthma	____Diabetes	____Nutritional/eating problems
____Attempted suicide	____Ear / Hearing problems	____Reflux/heartburn
____Bed-wetting	____Eczema / hives or skin conditions	____Seizures/epilepsy
____Birth defects	____Fibromyalgia	____Serious illness or injuries
____Bladder or kidney problems	____Head or spinal injury	____Sickle cell
____Blood diseases/abnormal bleeding	____Heart problems	____Speech problems
____Cancer	____High cholesterol	____Stroke
____Chicken pox	____High blood pressure	____Substance abuse
____Concussion / loss of consciousness	____Infectious disease	____Thyroid problems
	____Kidney stones	____Tonsillitis
____Constipation/bowel problems	____Liver disease	____Tuberculosis
	____Meningitis	____Vision/eye problems
____Dental problems	____Mental health conditions	____Wears glasses/contacts

Please describe any item marked above: _____

_____

Other (Please Specify): _____

_____

Place an X next to each condition that your child's FAMILY MEMBER has now or has previously had, and list how the family member is related to the student:

X	Condition	Relationship to Student		X	Condition	Relationship to Student
	Heart Attack/Heart Disease				Substance Abuse	
	Stroke				High Blood Pressure	
	Diabetes				Sickle Cell Trait/Anemia	
	Sudden Death Before Age 50				Kidney Disease	
	Seizures				Ashma/Allergies	

OTHER (specify): _____

List all current medications and dosages:

Medication Name	Dosage	Frequency	Reason/Condition

Is your child allergic to medicine or drugs? If so, please list: _____

Does your child have any food allergies or special diet? If so, please list: _____

Do you consider your child to be in good health? _____

Does your child have any serious illnesses or medical conditions? If so, please list: _____

Has your child had any surgeries? _____

Has your child ever been hospitalized? _____

Do you feel your family has enough to eat? _____