



ARBOR

FAMILY HEALTH

SCHOOL-BASED CLINICS

Arbor Family Health School Based Health Centers are excited to welcome back students for the new school year!

Our school based health clinic can help children succeed by providing convenient access to healthcare, behavioral/mental health services, and dental services, all while reducing student absenteeism as well as parental leave from work.

We are located on the Brusly Middle School Campus!

School Based Health offers:

- Transportation to and from schools
- Well child visits, sports physicals, and preventative screenings.
- Immunizations
- Sick visits that can include in house diagnostic testing for flu, COVID-19, and strep
- Behavioral health services
- Dental services: cleanings, filings, and x-rays
- Pharmacy Services (pick-up, delivery, or mail order)
- Telehealth/virtual visits
- Outreach Coordinator to assist with insurance applications

In order for your child to receive any of our services, the attached consent must be completed in full and returned to school or one of the two clinics.

To schedule an appointment call: 225-385-2668

For more information about our other services or any questions please call 1-888-711-3785.

We look forward to providing these services for your child!



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FAMILY HEALTH
 — BRUSLY —
 SCHOOL BASED CLINIC

Brusly School Based Health Center

Consent for Transportation

I, _____ (Parent/Guardian), give my permission for my child _____ to be transported from their school to/and from:

Brusly Elementary School
 400 South LaBauve Rd.
 Brusly, LA 70719

Brusly Middle School
 630 North Vaughn Dr.
 Brusly, LA 70719

Brusly High School
 658 North Vaughn Dr.
 Brusly, LA 70719

Brusly Upper Elementary School
 601 North Kirkland St.
 Brusly, LA 70719

Lukeville Upper Elementary School
 6123 LA Highway 1 South
 Brusly, LA 70719

Brusly School Based Clinic
 630 North Vaughn Dr.
 Brusly, LA 70719

In an Innis Community Health Center (IHC) van to receive medical/dental services during the school year.

If you wish to revoke your consent for transportation at any time, please call the Brusly High School Based Health Center at 225-385-2668 or 225-344-0008.

 Child's Name (PRINT)

 (Child's School and Grade)

 (Child's Date of Birth)

Cindy Peavy, Ed.D.

 Cindy Peavy, Executive Director

08/01/2023

 Parent or Guardian Name (PRINT)

 Date Signed

 Parent/Guardian Signature

[Signature]

 Dr. Chandler Smith, Superintendent

08/01/2023

 Date Signed



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LOUISIANA UNIFORM 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:	Religion:	Race:	Ethnicity:		
Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female							
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:		Next of kin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:	
Name of Father or Legal Guardian:			Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:	
Parent's E-mail:							
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.		<input type="checkbox"/> Medicaid/Healthy Louisiana #: _____ (check one below)					
		<input type="checkbox"/> Amerigroup of LA		<input type="checkbox"/> AmeriHealth Caritas LA		<input type="checkbox"/> Aetna Better Health	
		<input type="checkbox"/> LA Healthcare Connections		<input type="checkbox"/> United Healthcare Community Plan			
		<input type="checkbox"/> Medicaid (dental) #: _____					
		<input type="checkbox"/> No insurance					
		<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Is your child allergic to any food or medicine? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list:							
List of current medications student is on with dosage (how much) and how often:							

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.

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 Innis Community Health Center, Inc at 225-492-3775.

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
- ▲ Administration of over the counter medication as needed
- ▲ management of chronic diseases
- ▲ behavioral health services
- ▲ health education and prevention programs
- ▲ case management
- ▲ referral and follow-up for emergencies
- ▲ referral to specialty care
- ▲ Telehealth
- ▲ Teledentistry
- ▲ dental services (where available)
- ▲ fluoride varnish
- ▲ transportation to SBHC site at Brusly Middle School

I, as a 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 Innis Community Health Center or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Innis Community Health Center, Inc.

By signing below, 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 Brusly SBHC 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 school year to update important information.

We also understand that the School-Based Health Center is operated by Innis Community Health Centers, Inc. and its employees and contractors.

Printed Name of Parent/Legal Guardian

Relationship

Signature of Parent/Legal Guardian

Date

Signature of Student

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: Reviewed/Entered by: _____

Date: _____

Effective June 2023

Office use only.

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 Brusly School Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of Innis Community Health Centers, Inc. Notice of Privacy Practices that describes how my health information is used and shared. I understand that Brusly 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, at 225-384-2668 or 225-344-0008. My signature below constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

We consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the school nurse and the health center staff as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary 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 crisis or threat of grave or serious harm to self or others will be shared with the school principal.

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 healthcare provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, 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 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. I have read and understand the information in this form. I give permission for my child to have medical treatment at the Brusly High School Based Health Center. I am the legal guardian of the child.

I acknowledge receipt of the Notice of Privacy and understand I may call the Brusly SBHC at 225-385-2668 or 335-344-0008 to have any questions answered regarding The Notice of Privacy.

Signature: _____ **Date:** _____

Your Name (Please Print): _____



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STUDENT NAME: _____ DOB: _____ GRADE: _____

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

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies			Speech Problems
		Asthma (Please bring inhaler to clinic)			Mental Health Concerns/Depression
		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
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor appetite			COVID-19
					Other:

Student Surgical & Hospitalization History

Has your child ever had surgery? (If yes, please specify below) <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospital	Date	Reason

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				Other:	
		Other:				Other:	

Signature of Parent/Guardian _____	Date _____ Contact Number _____
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**Request
 to
 Immunize**

Patient Name: _____ Date of Birth _____

We are pleased to assist you in keeping your child healthy by completing immunizations that will be due this school year. Signing this form indicates that you will receive the VIS forms prior to administering immunizations and you request the School-Based Health Center give your child CDC recommended vaccines including:

Required Vaccines:

- HepA (Hepatitis A) Meningococcal
- HepB (Hepatitis B) Varicella (chickenpox)
- Tdap (Tetanus, diphtheris, acellar pertussis)
- MMR (Measles, mumps, rubella)
- Polio
- DTaP (Diphtheria, tetanus & acellular pertussis)

Optional Vaccines: Check Yes or No

- HPV (Human papillomavirus) **YES__NO__**
- Influenza **YES__NO__**

Please answer the questions below by circling "yes" or "no"

Has your child ever had the chickenpox disease?	Yes	No
Does your child have any allergies to medication, food or vaccine?	Yes	No
Has your child had a serious reaction to a vaccine in the past?	Yes	No
Has your child had a seizure or a brain problem?	Yes	No
Does your child have Cancer, Leukemia, AIDS or any other immune problem?	Yes	No
Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?	Yes	No
Has the student received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year?	Yes	No
Is your child pregnant or a chance she could become pregnant in the next month?	Yes	No
Has your child received vaccinations in the past 4 weeks?	Yes	No
Is your child allergic to eggs\chicken?	Yes	No
What Doctors office did your child receive his/her childhood vaccines? _____		

If you have any updated records at home, please send them to school with your child. We will make a copy and return your original.

If you would like the Brusly School Based Health Clinic to administer vaccines, please sign below. There is no cost to you for this service. Please call 225-385-2668 or 225-344-0008 if you have any questions or concerns.

Student Name _____ Date of Birth _____

I, (PARENT/GUARDIAN NAME) _____ give permission for my child to receive immunizations at the Brusly School Based Health Clinic. Please sign below as receipt of Vaccine Information Statements.

PARENT/GUARDIAN SIGNATURE

DATE