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: 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:

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 #: _____
❑ Aetna Better Health ❑ Healthy Blue ❑ AmeriHealth Caritas LA ❑ Humana Healthy Horizons
❑ LA Healthcare Connections ❑ United HealthCare Community Plan
❑ Medicaid (dental)#: _____ ❑ No insurance
❑ Private/Other Insurance Name: _____
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:

_____Asthma
_____Allergy
_____Tonsillitis
_____Seizures
_____Kidney Disease
_____Skin Problems
_____Been Restricted from Sports/PE for Medical Reasons
_____Nervous/Mental Disorder
_____Heart Disease or Murmur
_____Ear or Sinus Infections
_____Hearing or Speech Problems
_____Vision problems
_____Substance Abuse
_____Endocrine (Diabetes, Thyroid, Pituitary)
_____Infectious Disease -Hepatitis, HIV, TB, Meningitis
_____Missing Organ (Kidneys, Eyes, Testicles)
_____Blood Disorder or Birth Defects
_____Genetic Disorder or Birth Defects
_____Major Injuries
_____Other (specify)_____

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)
_____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)_____

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, carmex, 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, <u>will be given</u> 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 <u>MAY RECEIVE ALL IMMUNIZATIONS</u> OFFERED AT THE SCHOOL-BASED HEALTH CENTER EXCEPT THOSE WHICH I HAVE WRITTEN HERE or checked below:

I <u>DO NOT</u> WANT MY CHILD TO RECEIVE: (please check below if you <u>DO NOT</u> 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.

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 ♦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 Arbor Family Health 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 Arbor Family Health 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 (Iberville Parish, Pointe Coupee Parish, or West Baton Rouge 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 Arbor Family Health Services (Innis Community Health Centers, Inc.) and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student (optional) Date

_____ _____

Signature of School Health Staff Witness/Verify 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.

All services are provided by licensed professionals