



Outreach Consent Form

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) will be providing outreach services at your child's school this year. All children are invited to participate in CHC/SEK's outreach program. No child will be denied services based on insurance status or ability to pay. However, insurance, if available, will be billed. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please call 620-240-5061. Please complete this form in Ink.

School Name: _____

Student Name: _____ DOB: _____ Grade: _____ Gender: _____

Race:

- | | | |
|---------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> American Indian or
Alaskan Native | <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other
Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Race |

Ethnicity (circle one): Hispanic or Latino -OR- Not Hispanic or Latino

Do you want access to your medical records electronically? (circle one) YES OR NO

If yes, Email Address: _____

(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL)

Does the child have medical insurance? (circle one) YES OR NO

If YES, complete the insurance section below. CHC/SEK will bill your insurance for services provided.

- ☐ KanCare (Amerigroup, United Health Care, Sunflower) # _____
- ☐ Medicaid (Oklahoma or Missouri) # _____
- ☐ Commercial/ Private Insurance

Subscriber Name _____ DOB _____ SSN# _____

Insurance Company _____ Policy# _____ Group# _____

Parent/Guardian Name _____ Daytime Phone # _____

Address _____ City _____ State _____ Zip _____

Consent: As parent or legal guardian of the child named above, I give Community Health Center of Southeast Kansas, Inc. permission to provide my child with medical outreach services by CHC/SEK healthcare professionals. This consent is valid for one (1) year from the Parent/ Guardian Signature date below.

Parent/Guardian Signature _____ Date _____

Please complete and sign the Medical History Form on the other side

Medical History Form

Student Name: _____ DOB _____

Medical History: Please check all that apply

Heart Condition:	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Other: _____
Lung Condition:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Other: _____
Endocrine Condition:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Other: _____
Neurologic Condition:	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Concussion	<input type="checkbox"/> Other: _____
Bone/Joint Condition:	<input type="checkbox"/> Pins/Screws	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other: _____
Infectious Condition:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Other: _____
Behavioral Health:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Autism Spectrum
	<input type="checkbox"/> Other: _____		
Severe Allergy to:	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Bee/wasp stings	<input type="checkbox"/> Other: _____
	Reaction: _____		

Other Condition(s): _____

Does your child have special health care needs? (circle one) YES OR NO

IF yes, please explain: _____

Surgeries/Hospitalizations? (circle one) YES OR NO

IF yes, please explain: _____

Please list any known allergies (medications, foods, etc.): _____

Please list all medications your child is currently taking (including over the counter medications): _____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature _____ Date _____



Thank you for choosing Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your child's health care needs. CHC/SEK's school health clinic(s) is available for all students. By completing this form, you are helping CHC/SEK better take care of your child. If you have any questions call 620.240.5061. Please complete this form in ink.

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:
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Date of Birth _____ Male ☐ Female ☐ Social Security Number _____

Mailing Address _____ City _____

State & Zip _____ E-Mail Address _____ Phone Number _____

Do you want to access your medical records electronically? ☐ Yes ☐ No
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

Preferred method of communication for appointment reminders: ☐ Text ☐ Phone Call

School Name: _____

Patient Grade Level: _____ School Location (City, State): _____

Race:

- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Black or African American
- ☐ White
- ☐ Pacific Islander
- ☐ Other Race

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other _____

If you are Homeless, are you:

- ☐ On the Street
- ☐ Doubling Up
- ☐ In Transitional Housing
- ☐ In a Shelter
- ☐ Other

Other than CHC/SEK's school health clinic(s), who does the patient use for his/her medical care?
(Check all that apply) ☐ CHC/SEK ☐ Other: _____ ☐ N/A

RESPONSIBLE CAREGIVER

Name _____
Date of Birth _____
Relationship to the Patient _____
Mailing Address _____
City, State, Zip _____
Phone Number _____

Name _____
Date of Birth _____
Relationship to the Patient _____
Mailing Address _____
City, State, Zip _____
Phone Number _____

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, please provide appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

Please Complete the Back of Form

EMERGENCY CONTRACT

In the event of an emergency, who should we contact? _____

Relationship to Patient: _____

Phone Number: _____

INSURANCE INFORMATION (Check all that apply)

☐ KanCare (Aetna, Sunflower, United HealthCare)

☐ Kansas Farmworker Health Program

☐ No Health Insurance (Staff are available to help determine if you are eligible for coverage)

☐ Commercial Insurance

☐ Medicare

☐ Other Medicaid

Primary Insurance

Insurance Plan _____

Member ID Number _____

Group Number _____

Policy Holder Information:

Full Name _____

Date of Birth _____

Social Security Number _____

Relationship to Patient _____

Employer _____

Secondary Insurance

Insurance Plan _____

Member ID Number _____

Group Number _____

Policy Holder Information:

Full Name _____

Date of Birth _____

Social Security Number _____

Relationship to Patient _____

Employer _____

Pharmacy: _____

Name

City & State

****Apothecare, located in CHC/SEK's Pittsburg, Fort Scott, Pleasanton, Iola, and Columbus clinics, is CHCSEK's preferred pharmacy.**