Smackover-Norphlet School Based Health Center

PARENTAL CONSENT FORM

Student Name: _____ Date of Birth: _____

Address (Street, Apt, City, State, and Zip):_____

Parent/Guardian Name: (printed):_____

Parent/Guardian's Phone Number: _____

Second Contact Number (optional):_____

I understand the following types of services are offered through the Smackover-Norphlet School Based Health Center:

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Treatment of minor injuries
- Laboratory Tests
- Health Education, counseling, and wellness promotion
- Nutrition education and weight management
- Prescription medications
- Behavioral Health Services
- Referrals for services not provided by the School Based Health Center

I understand the following types of dental services are offered by Dr. Taylor D. Everett at the Smackover-Norphlet School Based Health Center.

- Routine Dental Exams
- Dental Radiographs
- Dental Cleanings
- Sealants
- Fillings
- Root Canals
- Stainless Steel Crowns
- Extractions

All parental consents must be accompanied by a completed registration form and health history form

Your insurance may be billed for this service.

I understand that information may be shared with the school nurse and my primary care physician when pertinent to my child's health and also authorize the school nurse and primary care physician to share information with the School Based Health Center when pertinent to my child's health.

I give my permission for the Smackover-Norphlet School Based Health Center to provide medical care, illness prevention and wellness promotion programs to the student named above.

By signing below, I am granting permission for the Smackover School Based Health Center in partnership with Dr. Taylor Everett, DDS, PA to provide dental services and education to the student named above.

I give my consent, permission, and/or authorization for the Smackover-Norphlet School District to transport my child to and from medical appointments at Dr. Taylor Everett's office located at 807 Lisbon Ave and/or the School-Based Health Center.

Assignment of Benefits and Privacy Notice

☐ I authorize the Smackover Family Practice Clinic to file my insurance for services provided.

☐ I have been notified of the Smackover Family Practice Clinic's Privacy Practices for Protected Health Information.

Responsible Party Name _____Patient Name_____

_____ _____

Responsible Party Signature Date

- ❖ I understand that this consent is good from the date above until my child graduates or moves out of the district. I also understand that if I would like to opt out of any service offered by the SBHC that I will need to submit that in writing to the SBHC office.

All parental consents must be accompanied by a completed registration form and health history form