West Feliciana Parish School System

Family Service Center

Louisiana Enrollment/Consent Form

For School-Based Health Centers

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| 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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (check one below)  ❑ Aetna Better Health ❑ Amerigroup Real Solutions ❑ AmeriHealth Caritas LA  ❑ LA Healthcare Connections ❑ United HealthCare Community Plan  ❑ Medicaid (dental)#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ No insurance  ❑ 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? ❒ No ❒ Yes | | | | | | | | | | | |

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| 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: |
| **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.  We understand that the SBHC is funded through the Office of Public Health (“OPH”) Adolescent School Health Program and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose. |
| **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 the Family Service 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 Family Service 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 225-635-5299. 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. |
| NOTE: If you do not consent to these services, your child will still receive limited health services through the School Nurse, including vision and hearing screenings. Your child will not be able to receive OTC medications, physician services, or counseling through the Family Service Center. |

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| **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 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 |
| 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 Family Service Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the Family Service Center.  **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 West Feliciana Parish School system 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 the West Feliciana Parish School System and its employees and contractors. |
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