Health History Form and Consent to Treat

A. Student Information

Name **Gender** **Date of Birth** **Age** **Social Security #**

Mailing Address **City** **Zip** **Telephone#**

Name of Insurance Co. **Group #** **Claim #**

Name of Guarantor **Guarantor Date of Birth** **Relationship**

Emergency Contact **Relationship** **Telephone #**

Secondary Emergency Contact **Relationship** **Telephone #**

Race/Ethnicity: __White/Caucasian __African American/Black __ Hispanic/White __Asian __Native Hawaiian
__ American Indian __ Other Pacific Islander __Refuse to Report

Name of Primary Care Provider/Physician **Address** **Telephone #**

Name of Pharmacy **Address** **Telephone #**

In order to determine eligibility for patient assistance programs and for federal reporting necessary to continue funding for this facility, please complete:

Number of Household Dependents: _____ **Gross Household Income: $_____**
Does the student receive free/reduced lunch? **YES** **NO**

Please circle any options that apply to the patient: **Veteran** **Homeless** **Live in Public Housing** **Migrant** **None**

B. Personal and Family History: Please check all that apply regarding present and past health history:

	Student	Mother	Father	Grandparents	Sister/Brother
Asthma					
Anemia					
Allergies					
Birth Defects					
Behavioral Concerns					
Cancer/Tumor					
Chickenpox					
Diabetes					
Depression					
High Blood Pressure					
Heart Attack/Disease					
Kidney Disease					
Sickle Cell					
Seizures					
Stroke					
Whooping Cough					
Liver Disease					
Skin Conditions					
Stomach Problems					
Mental Illness					
Other:					

Allergies (including food, pollens, odors, medicines, pets, etc) **___ YES** **___ NO**

If yes, please list: _____

Current Medications (including vitamins/OTC/Supplements)	**Dose:**	**Times/Day:**

Previous Hospitalizations: ___ **YES** ___**NO**
Past Surgery: ___ **YES** ___ **NO**
If yes, please list specific information below:

Reason	**Location**	**Month/Year**

Please list any other medical problems that your child has that we need to know about:

_____
_____
_____
_____
_____

***Please note that a School Care Plan/Physician's written diagnosis is required for all special medical needs concerning your child, such as a special diet, allergies, asthma, seizures, etc.**

C. Primary Care Provider Referral Agreement
In order for East Arkansas Family Health Center, Inc. to receive reimbursement from Medicaid or commercial insurance, a referral from the current PCP may be required. However, if a referral cannot be received from the PCP, East Arkansas Family Health Center, Inc. asks the parent to change the student's PCP to East Arkansas Family Health Center, Inc. in order to receive reimbursement for services. All patients may apply for Sliding Fee discounts.

D. Financial Assistance
In an effort to ensure that payment of fees is not a barrier to care, East Arkansas Family Health Center, Inc. offers those who need it a waiver of fees. All waivers will be specific to location and services approved.
___ **YES, I request a waiver of fees.**

___ **NO, I do not request a waiver of fees.** I understand all services will be billed directly to me including co-pays and deductibles for services rendered.

E. Transportation Consent

It may be necessary for the student to be transported to the Health Center. If so, I give consent for my child to be transported to the Health Center by a school employee.

___YES, I consent to my child being transported.

___NO, I do not consent to my child being transported.

F. Consent to Treat- School Based Health Center
I understand that the School Based Health Center can provide health services to my child. One consent form per child must be signed and on file in order for the student to receive services.

By signing below, I hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the provider. I further understand that any services provided but processed by a third party contractor (AEL Corp) such as routine laboratory work (including but not limited to blood, urine, and/or swabs) may be billed to me directly. I

further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, including nurses, as is necessary per provider judgment.

Regarding release of information: (a) I authorize the clinic to release medical information to the third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care. (b) I further authorize the release of medical information about treatment here to my (his/her) doctor or any designated by me for continuity of care. (c) I further authorize the ability to view prescriptive history from external sources. (d) I further authorize the release of medical information to federal and state governing entities for the purposes of required reporting.

I understand that the Arkansas State Medical Board, Arkansas State Board of Nursing, and other federal and state agencies license and regulate all medical providers, including East Arkansas Family Health Clinic, Inc. (EAFHC) and its health care providers and staff. Marion School District (MSD) provides space and access to this clinic for its staff and students but does not provide oversight for the provision of medical services through this School Based Health Center. I and my child/ward agree to hold harmless MSD, its employees and agents for any and all claims that may arise through the provision of medical services given, authorized, or directed by EAFHC, its employees, independent contractors, and agents. Further, I and my child/ward agree to hold harmless MSD, its employees and agents for any and all claims that may arise during the transportation of my child/ward to and from the EAFHC clinic whether the transportation is in a privately owned vehicle or in a vehicle owned by MSD.

I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the School Based Health Center and that no person is turned away due to the inability to pay. I understand that the Notice of Privacy Practices document has been provided to me.

_____**YES! I consent for my child to receive <u>MEDICAL</u> care through the School Based Health Center (examples: physical exams, well child visits, lab, evaluation of injuries, vaccinations, and chronic disease management).**

_____	_____	_____
Signature of Parent/Guardian	**Relationship**	**Date**

G. Denial of Consent to Treat- School Based Health Center.

_____ **No, I do not wish for my child to receive medical care through the School Based Health Center.**

_____	_____	_____
Signature of Parent/Guardian	**Relationship**	**Date**