SOUTHEAST COMMUNITY HEALTH SYSTEMS
CONSENT FORM
St. Helena Parish School System

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	Race:	Ethnicity:	
Student's Social Security Number:		School: ❑ Arts & Technology Academy ❑ College & Career Academy		Student's Grade:	
Preferred Language:	Student's 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: ( )	
Student's Primary Care Physician:				Phone: ( )	
Student's Dentist:				Phone: ( )	
Preferred Pharmacy:	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/Bayou Health Plan #: _____ (check one below)

❑ Amerigroup of LA ❑ AmeriHealth Caritas LA ❑ Aetna

❑ LA Healthcare Connections ❑ United Healthcare of LA

❑ 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

If your child does not have health insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

Is your child allergic to any food or medicine? ❒ No ❒ Yes If yes, list:

Student's Name: _____ 2nd Identifier _____

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.

Southeast Community Health Systems can serve as the student's primary healthcare provider by way of their patient centered medical home base. The patient-centered medical home is a health care setting that facilitates partnerships between patients and their personal physicians, and when appropriates, the patient's family. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

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 (where available)

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 Southeast Community Health Systems or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Southeast Community Health Systems.

We (student and parent/guardian) 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.

We also understand that the school-based health center is operated by Southeast Community Health Systems and its employees and contractors.

Student's Name: _____ 2nd Identifier _____

Southeast Community Health Systems has an MOU with St. Helen Parish School Board to offer medical, dental and behavioral health services through Southeast Community Health Systems" School Based Health Center to students and staff at the St .Helena College & Career Academy. SCHS and St. Helena Parish School Board works collaboratively in meeting the whole need of the population served.

√_____ Relationship: _____
Printed Name of Parent/Legal Guardian

√_____ Date: _____
Signature of Parent/Legal Guardian

√_____ Date: _____
Signature of Student

_____ Position: _____
Printed Name of School Health Witness/Verify

_____ Date: _____
Signature of School Health Witness/Verify

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.

Louisiana state law prohibits health centers in schools 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 504-568-8164.

Effective July 2015

Student's Name: _____ 2nd Identifier _____

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment to me and/or my dependent by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatment by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries or carriers or any other insurer any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at anytime.
9. I certify that the information provided is true to the best of my knowledge.

Signature of Parent/Guardian: √_____ Date:_____

MINOR CONSENT:
I ATTEST THAT I HAVE REVIEWED THE ABOVE AND AM AWARE OF ITS CONTENTS.

Note: If the patient is a minor, the parent, guardian, or relative gives consent for the minor under his/her care. Print the name of the minor on the first line. Print and sign the name of parents, guardian, or relative on the second line. Relationship and telephone are also required. If minor is emancipated, legal documents from the court are required.

_____
Patient (MINOR) For Legal Minors:

BY: √_____ _____
Print Name of Person giving consent Relationship to Patient

√_____ _____
Signature of Person giving consent Telephone Number

Student's Name: _____ 2nd Identifier _____

PATIENT'S RIGHTS

I have read and understand my rights and responsibilities as a patient of Southeast Community Health Systems (SCHS) and understand that if the quality of my care is compromised and if SCHS management staff or quality assurance committee cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission on Accreditation of Healthcare Organizations at (800) 994-6610, or email complaint@jointcommission.org.

Signature of Parent/Guardian: √_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I wish to place the following restrictions on disclosure of my child's health information (Please list below or write N/A if no restrictions):

_____

_____

Signature of Parent/Guardian: √_____ Date: _____

Relationship to Student: √_____

Student's Name: _____ 2nd Identifier _____

THE FOLLOWING LIST OF MEDICATIONS WILL BE ADMINISTERED BY THE NURSE AS PER PHYSICIAN'S STANDING ORDERS:

ACETAMINOPHEN (Tylenol) for pain, fever

MYLANTA or MAALOX for upset stomach

ORAGEL for tooth/mouth pain

HYDROGEN PEROXIDE to clean wound

NEOSPORIN to apply to cuts, wounds, etc

IBUPROFEN (Advil, Motrin) for pain fever

ROBITUSSIN COUGH SYRUP to loosen congestion

BENADRYL for allergic reaction or allergies

PHENYLEPHRINE for allergies/nasal congestion

VISINE CLEAR EYES for allergy/itchy eyes

ALBUTEROL NEBULIZER for wheezing

ROBITUSSIN DM for cough

CHAPSTICK for chapped lips

HYDROCORTISONE CREAM for itching, minor skin irritation

CLARITIN for allergies, nasal congestion

CLARITIN D for allergies, nasal congestion

DEBROX to soften ear wax

EYE WASH SOLUTION to flush eyes

COUGH DROPS to suck on to quiet cough

CALAMINE/CALADRYL LOTION for pain/itching

AURALGAN for ear pain

EMETROL for nausea

SILVADENE for burns

KAO-PECTATE for diarrhea

THROAT LOZENGE for sore throat

NAPROXEN for pain or sports injury

******NOTE: GENERIC FORM MAY BE SUBSTITUTED******

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL BASED HEALTH CENTER **EXCEPT** THOSE WHICH I HAVE WRITTEN HERE:

_____

_____

Signature of Parent/Guardian: √_____ Date:_____

Student's Name: _____ **2nd Identifier _____**

FAMILY HISTORY – PARENTS, GRANDPARENTS, SIBLINGS

___ Seizure/Epilepsy
___ Cancer
___ High Blood Pressure
___ Diabetes
___ Tuberculosis
___ Asthma
___ Allergies
___ Kidney Disease
___ Sickle Cell
___ Glaucoma
___ Mental Illness
___ Heart Disease
___ Other

PATIENT'S HISTORY

___ Mumps
___ Chicken Pox
___ German measles
___ Learning Disabilities
___ High Blood Pressure
___ Mental Illness
___ Anemia
___Allergies
___ Sickle Cell
___ Diabetes
___ Seizures
___ Asthma
___ Other

Has this child ever had any surgeries (operations) or major injuries? ___ Yes ___ No

If yes, please describe:_____

Has this child ever been hospitalized? ___ Yes ___ No

If yes, when and what for? _____

BIRTH HISTORY: Was your child born early ___ on time ___ or late ___? **Birth Weight:** ___lbs ___ oz

Any complications with infant at birth ___ Yes ___ No

If yes, please describe: _____

Did mother use drugs or alcohol during pregnancy? ___ Yes ___ No

FEMALES: Has her menstrual periods started? ___ Yes ___ No If yes, at what age? ___

Are her periods painful? ___ Yes ___ No Has child ever been pregnant? ___ Yes ___ No

Is child on birth control? ___ Yes ___ No If yes, what kind? _____

MALES: Has that child had or has any problems with his penis or testicles? ___ Yes ___ No

If yes, describe:_____

SOCIAL HISTORY: Who does the child currently live with?

_____

Is the child sexually active, use drugs or alcohol? ___ Yes ___ No

If yes, describe: _____

_____

Person who furnished information: ___ Patient ___ Parent ___ Family ___Guardian ___ Other

Relationship to Patient: _____

*****ALL INFORMATION GIVEN ABOVE IS KEPT PRIVATE AND CONFIDENTIAL*****