LOUISIANA ENROLLMENT/CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS

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

HEALTH HISTORY:

Has your child ever been admitted into a hospital or had surgery? Yes_____ No_____ If Yes, Year:_____

Reason: _____ Hospital:_____

Please mark the item(s) that apply to your child's medical history:

_____Asthma	_____Nervous/Mental Disorder	_____Endocrine (Diabetes, Thyroid, Pituitary)
_____Allergy	_____Heart disease or Murmur	____Infectious Disease -Hepatitis, HIV, TB, Meningitis
_____Tonsillitis	_____Ear or Sinus Infections	_____Missing Organ (Kidneys, Eyes, Testicles)
_____Seizures	_____Hearing or Speech Problems	_____Blood Disorder or Birth Defects
_____Kidney Disease	_____Vision problems	_____Genetic Disorder or Birth Defects
_____Skin Problems	_____Substance Abuse	_____Major Injuries
_____Been Restricted from Sports/PE for Medical Reasons		_____Other (specify)_____

Please describe any item marked:

Has your child ever had Chickenpox? _____

FEMALES: List dates for: First Menstrual Period_____ Last Menstrual Period_____

FAMILY HISTORY:

Please mark the item(s) that apply to your family's history: (brothers, sisters, parents and grandparents)

_____Asthma	_____Nervous/Mental Disorder	_____Endocrine (Diabetes, Thyroid, Pituitary)
_____Allergy	_____Heart Disease or Murmur	_____Infectious Disease -Hepatitis, HIV, TB, Meningitis
_____Tonsillitis	_____Ear or Sinus Infections	_____Missing Organ (Kidneys, Eyes, Testicles)
_____Seizures	_____Hearing or Speech Problems	_____Blood Disorder or Birth Defects
_____Kidney Disease	_____Vision problems	_____Genetic Disorder or Birth Defects
_____Skin Problems	_____Substance Abuse	_____Major Injuries
_____Been Restricted from Sports/PE for Medical Reasons		_____Other (specify)_____

Please describe any item marked (Who/When):

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:

MEDICATION CONSENT:

The School-Based Health Center will administer medications per the Provider's orders. Over the Counter medications may be administered such as Pain Relievers, Cold medications, Ear drops, Eye drops, Stomach medication (Pepto-Bismol, Mylanta, Midol), Wound medications, Anti-itch medication, and other topical creams/gels for other complaints, such as orajel, carmex, or Vaseline. Prescription medication may be given if found necessary after examination as well. Injections, such as Antibiotic injections or Steroid injections may be given if deemed necessary by the provider. Nebulizer medications may be administered for asthma type symptoms if necessary for treatment of students.

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

IMMUNIZATION CONSENT POLICY:

At each visit, LINKS, the Louisiana Immunization Network for Kids Statewide, will be checked to see if your student is up to date on all age-appropriate vaccines, including FLU and HPV, according to CDC guidelines. If the student is not up to date at the time of the exam, a separate consent, listing each vaccine your child is due for, will be sent home with the student. Upon return of the signed immunization consent, your child will receive those vaccines for which you have given consent, bringing him/her up to date. I UNDERSTAND THIS STUDENT WILL NOT RECEIVE ANY VACCINES WITHOUT RETURNING THE IMMUNIZATION CONSENT SIGNED BY A PARENT/GUARDIAN.

IN ADDITION, NO STUDENT WILL RECEIVE A COVID VACCINE WITHOUT A SEPARATE COVID VACCINE CONSENT BEING SIGNED AND A PARENT/GUARDIAN MUST BE PRESENT FOR THE STUDENT TO RECEIVE A COVID VACCINE.

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 Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC 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 Center (SBHC) adheres 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 School-Based Health 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 School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center. 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.

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 (see Immunization consent policy above) ♦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 provided by either CommuniHealth Services or ULM Dental Hygiene School either on-site or via mobile dental unit ♦Telemedicine services

*Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables a health care practitioner and a patient at two different locations separated by distance to interact via two-way video and audio transmission simultaneously. Services provided by Telemedicine are provided by CommuniHealth Services employees, contractors, or affiliates and include primary care, behavioral health and specialty 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 School-Based Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to CommuniHealth Services.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided, including the medication consent and Telemedicine services, at the school-based health center. We both give permission for this student to receive the services provided by the program. Regarding the use of telemedicine, the relationship between the treating provider and all other providers involved in my child's care have been thoroughly explained to me and I acknowledge their respective roles in the treatment of my child. Further, I acknowledge my right to withdraw/cease care via telemedicine at any time. **This consent is effective while the student is enrolled in (Ouachita Parish, Morehouse Parish, or Union Parish Schools, as applicable) 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 CommuniHealth Services (formerly Morehouse Community Medical Centers) and its employees and contractors.

_____	_____
Printed Name of Parent/Legal Guardian/Student	Relationship
_____	_____
Signature of Parent/Legal Guardian	Date
_____	_____
Signature of Student (optional)	Date

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.

Dental Consent Form

Student's Name: _____ Student's Date of Birth: _____

1. Does your student have a dentist he/she sees routinely? __ No __Yes Dentist's name: _____
2. When did your student last have their teeth cleaned? __ Not sure __ 6 months ago __ 12 months ago
3. When did your student last have dental x-rays taken? __ Not sure __ 6 months ago __ 12 months ago
4. Is your student having any medical or dental problems, pain, or discomfort at this time? If so, please describe.

_____

5. Has your student ever experienced any complications of any kind during dental treatment? __ No __ Yes

   If yes, please explain: _____
6. Please list any allergies your student has_____
7. Please list any medical conditions your student has_____ \

   _____
8. Please list any prescription medications your student takes_____

   _____

I consent for my child to receive the following dental services:

- Dental cleanings – Dental cleanings involve removing plaque (soft, sticky film) and tartar that has built up on the teeth over time, polishing the teeth, x-rays, and fluoride treatment.
- Sealants - A thin protectant material that coats the chewing surfaces of the back teeth to prevent cavities.
- Teledentistry - Teledentistry is a way to provide care for people who do not or cannot go to a dental office. It allows for the dental hygienist to provide dental cleanings, x-rays and sealants under the supervision of a dentist working at a remote location. Teledentistry uses electronic dental records, such as electronic versions of x-rays, intra-oral photographs, recordings of the condition of teeth, health, and other historical information. I understand the dental provider wishes to engage in a teledentistry visit(s). I understand how the teledentistry visit will be conducted and by choosing this method, there is a risk of interruption and technical difficulties. I understand that these visits will not be the same as a direct patient/dental provider visit because my child will not be in the same room as the dentist. I understand that I have the right to refuse teledentistry visits at any time or to end it at any point during the visit. I understand that if I do not wish for my child to participate in a teledentistry visit, I will need to make an appointment for an in-person visit. I further understand that the dental provider may not be able to accommodate an in-person visit on the same day and there may be a delay in my child's care if I choose an in-person visit. I understand that the dental provider can discontinue the teledentistry visit if he or she believes that this technology does not meet the standard of care necessary to address my child's dental concerns. I understand that I have the right to review and/or obtain a copy of the dental record by contacting the dental provider's office for instructions.

Potential complications from these procedures include, but are not limited to: sensitivity, swelling, and bleeding of the gums. **Any additional dental services will have a separate consent to be signed prior to the services being provided**. The patient's medical history will be updated at every visit. If your student has a dentist that he/she sees on a regular basis, we encourage you to continue to seek care through that provider.

I, the parent/guardian, understand that I will not be charged for any of the services provided through the School Based Health Center (SBHC). I also understand the SBHC, or the dentist may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the School Based Health Center. I understand that the dental services billed to the student's insurance company may be counted towards any annual benefit limitations. I attest that I am the parent or legal guardian of this student and have legal authority to sign this consent form.

This consent is effective while the student is enrolled in (Ouachita Parish, Morehouse Parish, or Union Parish Schools, as applicable) unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive dental services.

_____ _____

Signature of Parent/Guardian Date

EMERGENCY CONTACT 24/7: CommuniHealth Services (318)283-8887