LSUHSC SCHOOL-BASED HEALTH CENTERS

ENROLLMENT and CONSENT FORM

Student name

First ________________________ **Middle Initial**________ **Last**_______________________________

Student Date of Birth ______/______/________ **Sex/Gender** ________________________________

Student's Address ____**Zip Code** __________

Student Cell # ________-________-_________**Social Security Number** _________________________

Student school email address ____________________________________ **GRADE** ___________

Race ___________________ **Ethnicity** ___________________ **Language** _________________

Student's Primary Care Physician ____

Preferred Pharmacy ____

Legal Guardian 1

Name_____________________________________ Cell Phone ___________________

Relationship_____________________ Alternate Phone _________________________

Email __________________________________

Legal Guardian 2

Name ____________________________________ Cell Phone ____________________

Relationship _____________________ Alternate Phone _________________________

Email __________________________________

Emergency Contact 1

Name ____________________________________ Cell Phone ____________________

Relationship _____________________ Alternate Phone _________________________

Student's Medical Insurance

NO insurance ________**Medicaid/Healthy Louisiana #** ____________________________

Private Insurance Name ______________**Policy #** ________________________ **Group #** __________

Company Address _________________________**Company Phone #** _________________________

Effective Date: ________ Name of policy holder: _____________ Policy holder date of birth: _______

Relationship to student ___________________________

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Student Health Information

Allergies to Medication or food ____

____

Current Medications ____

____

Chronic Health Conditions (Check all that apply)

ADHD _____ Asthma _____ Anxiety/Depression _____ Cancer ____ Diabetes _____

Heart problem _____ Hearing loss _____ Seizures _____ Vision problem _____

Sickle Cell Disease/Trait _____ Physical/Mobility disability _____

Other (Please list) ____

Special Accommodations 504 plan _____ IEP _____ IHP ______

Telemedicine
I consent to having some or all of my medical services provided by video or other interactive telecommunication technology as allowed by law. I understand that I may decline to receive medical services via telemedicine or withdraw from such care at any time.

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 LSUHSC SBHC and the student's personal physician 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 LSUHSC SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 504-613-5648. 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.

Patients Name:____ Date ______________________

Signature of Parent/Legal Guardian: ____

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BY SIGNING THIS CONSENT YOU ARE AGREEING TO ALLOW THE SCHOOL-BASED HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD UPON REQUEST:

Primary and preventive health care, comprehensive and sports physical exams, immunizations, health screenings, laboratory and diagnostic testing, acute care for minor illness and injury including administration of medication if indicated, management of chronic diseases with PCP, Behavioral Health services including psychiatry, health education and prevention programs, case management, referral and follow-up for emergencies, referral for specialty care, vision services, Telehealth appointments.

I, as legal guardian, understand that I will not be charged for any of the services provided at the school based health center. I also understand that LSUHSC SBHC or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to LSUHSC SBHC.

By signing below, we (student and parent/guardian) acknowledge that we have read and understood the services to be provided at the school-based health center. We give permission for the student to receive the services provided by the program.

This consent is effective while the student is enrolled in LSUHSC School-Based Health Center unless LSUHSC SBHC 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 new form annually to update important information.

We also understand that the school-based health center is operated by LSUHSC Department of Pediatrics Adolescent Medicine Division and its employees and contractors.

Parent/Guardian Signature ______________________________ **Date** ______________________

Parent/Guardian Printed name ____

Student Signature ______________________________________ **Date** _____________________

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to LSUHSC Department of Pediatrics School Based Health. A duplicate copy of this document is available upon request.