LSUHSC SCHOOL-BASED HEALTH CENTERS
LOUISIANA ENROLLMENT/CONSENT FORM

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:			Student's Grade:	
Preferred Language:	Student 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 ❑ Healthy Blue ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑ United HealthCare of Louisiana

❑ 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

Office use only.

Student's Name: _____ 2nd Identifier _____

List of current medications student is on with dosage (how much) and how often:

List of all illnesses or injuries:

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

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.

_____ _____

(Patient's name – please print) Date

_____

Signature of Patient or Parent/Legal Guardian

Office use only.

Student's Name: _____ 2nd Identifier _____

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) ♦telehealth 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 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 understand the services to be provided at the school-based health center. We give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in LSUHSC School-Based Health Centers) 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 **LSUHSC Department of Pediatrics, Adolescent Medicine Division** and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student 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.

ALL SERVICES ARE SUPERVISED BY LICENSED PROFESSIONALS