LOUISIANA UNIFORM CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS

Student's Name: Last	First	Middle Initial			ID#(office use only)
Student's Address:					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'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:

❑ Medicaid/Bayou Health Plan #: _____ (check one below)

❑ Amerigroup ❑ Community Health Solutions ❑ LaCare

❑ LA Health Connections ❑ United Healthcare

❑ 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:

List of current medications student is on:

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
♦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)

Student's Name: _____ Date of Birth:_____

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 St. Martin Parish School-Based Health Centers or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the St. Martin Parish School-Based Health Centers.

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 health center is operated by the St. Martin Parish School Board and its employees and contractors.

Confidentiality: 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 **St. Martin Parish School-Based Health Centers (SBHC'S)**, 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 St. Martin School-Based Health Centers has the right to change this notice at any time. I may obtain a current copy by contacting the Health Center Coordinator. My signature below constitutes my acknowledgement that I have been provided with a copy of the ***Notice of Privacy Practices***.

I understand that my health information is stored in a unified electronic medical record system (SuccessEHS) owned and operated by the St. Martin Parish School-Based Health Centers which is sponsored by the St. Martin Parish School District. The Notice of Privacy Practices describes how my health information may be used or disclosed by the St.Martin Parish School-Based Health Centers. I understand that I should read it carefully and I am aware that the Notice may be changed at any time.

I understand that my health information will be reported to the Louisiana Health Information Exchange (LaHIE) and that I have the right to opt in or opt out of participation in sharing information with participating organizations. I have the right to revoke consent any time, or if I have previously chosen to opt out, I have the right to change my mind and opt in at any time. Option choices must be in writing.

We consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the school nurse program and the health center staff as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal.

The school board and the school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than (1) a health care provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate consent given on the Attachment.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment.

Student's Name: _____ Date of Birth:_____

ST. MARTIN PARISH SCHOOL-BASED HEALTH CENTERS

COMPREHENSIVE PATIENT AND FAMILY HISTORY

BIRTH AND DEVELOPMENTAL PATIENT HISTORY

Was child born full term? _____ Premature? _____ Any problems during pregnancy? _____
Type of delivery? _____ Child's Birth Weight? _____ Child's Birth Length? _____
Did your child have any of the following problems after birth (circle if yes):
Jaundice Convulsions Bleeding Trouble Breathing
Feeding Problems Special Formula Excessive Vomiting Other_____
When did your child crawl? _____sit alone? _____stand without help? _____walk? _____
Is your child toilet trained? _____ If yes, at what age? _____
Where has your child received his/her immunizations in the past? _____

SEND COPY OF THE IMMUNIZATION RECORD

Please circle any item(s) that applies to your child's medical history:

Heart Disease	*Communicable Disease*	*Genetic Disorder*	*Meningitis*
Endocrine Disease	*Substance Abuse*	*Ear Infection*	*Tonsillitis*
Major Injuries	*Speech Problems*	*Birth Defects*	*Kidney Disease*
Allergy	*Sickle Cell Trait*	*Sickle Cell Disease*	*Asthma*
Seizures	*Other (specify)_____*		

Please describe any item circled:_____
_____

*Has your child ever been admitted into a hospital? **(Please circle)** YES NO*
If yes, please answer the following:
Name of Hospital_____ Date of Admit_____ Reason:_____

FAMILY HISTORY

Please circle:
What type of water supply do you have? CITY / WELL What type of sewer do you have? CITY / SEPTIC

How many pets are living in your home? _____How many smokers are living in your home? _____

Please circle any item(s) that applies to your family's medical history:

Genetic Disorder	*High Blood Pressure*	*Tuberculosis*	*Cancer*	*Seizures*
Heart Disease	*Asthma*	*Stroke*	*Nervous/Mental Disorder*	*Anemia*
Sickle Cell	*Diabetes*	*Allergies*		

Other (specify)_____
Please describe any item circled:_____
_____

Student's Name: _____ Date of Birth:_____

LOUISIANA HEALTH INFORMATION EXCHANGE OPTION

(please check one option)

☐ **Opt-In to LaHIE**
When you seek medical treatment at an organization participating in LaHIE, your health information is accessible.

☐ **Opt-Out of LaHIE**
If you choose to opt out of LaHIE, your health information cannot be accessed through LaHIE, even in an emergency situation.

☐ **No Option selected**
If you have a health emergency, and your consent has not been obtained, your electronic health information may be accessed for emergency treatment purposes only.

_____ Relationship: _____
Signature of Parent/Legal Guardian

_____ Date: _____
Printed Name 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.

ALL SERVICES ARE PROVIDED BY LICENSED AND CERTIFIED PROFESSIONALS.

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.

Student's Name: _____ Date of Birth:_____