Health Centers in Schools

A Partner of OUR LADY OF THE LAKE CHILDREN'S HEALTH

HOW TO

Complete Electronic Consent and Demographic form

1

Fill in all of the blanks on the consent portion including signature on page 2.

2

Fill in all of the blanks on the demographic form on page 3.

Completing every details is important to ensure an accurate history.

3

Once all 3 pages are complete, please EMAIL them to:

hccs@fmolhs.org

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School Based Health Authorization

Student's Name: ________________________________ Date of Birth ________________________

I understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to SBHC's 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. I understand that the School Based Health Centers (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.

Confidentiality: The 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) and the Family Educational Rights and Privacy Act (FERPA). I consent to the exchange of relevant health information between Health Centers in Schools and the student's personal medical provider or Our Lady of the Lake Physician Group provider 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 Health Centers in Schools has the right to change this notice at any time. I may obtain a current copy by contacting the Health Centers in School's main office, at (225) 343-9505. My signature below constitutes my acknowledgment 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 504-5683504.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW HEALTH CARE CENTERS IN SCHOOLS TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

- Primary and preventive health care
- Comprehensive history and physical examinations health screenings
- Laboratory/diagnostic testing
- Case management
- Acute care for minor illness/injury (including medications), if indicated
- Management of chronic diseases
- Behavioral health services
- Referral and follow-up for emergencies
- Referral to specialty care
- Health education & prevention programs
- Dental services (where available)
- Telehealth visits with a primary care, specialty, or behavioral health care provider

Please initial below:

_______If my child requires COVID-19 testing, I do hereby consent to HCCS or Our Lady of the Lake Physician Group administering COVID-19 testing and notification of results.

_______I do consent to HCCS staff administering immunizations according to the American Academy of Pediatrics immunization schedule and CDC guidance.

Student's Name: ________________________________Date of Birth ________________________

I understand that there will not be payment required for any of the services provided at the school-based health center. I also understand that **Health Centers in Schools** or the medical provider will bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to **HCS**.

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 both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in an East Baton Rouge Parish Schools 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 **OLOL Children's Health Centers in Schools** and its employees/contractors and not by the local school board.

________________________________ ________________________________
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.

Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures.

Effective Date: December 23, 2020

LOUISIANA ENROLLMENT CONSENT FORM FOR HEALTH CENTERS IN SCHOOLS (HCS) 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	**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 (Name, Street and Phone Number)		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 Plan (formerly Bayou Health) #: ____________________________ (check one below)

❑ Amerigroup Real Solutions LA ❑ AmeriHealth Caritas LA ❑ Aetna Better Health LA

❑ LA Healthcare Connections ❑ United Healthcare Community Plan LA

❑ Medicaid (dental) #: ____________________________

❑ No insurance

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

❑ Private/Other Insurance Name____

Employer/ 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

Is your child allergic to any food? Medicine? Insect? Latex? Other? ❒ No ❒ Yes If yes, list:

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

MEDICAL AND HOSPITALIZATION INFORMATION:

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

Reason: ____ Hospital: ______________________________________

Date of last comprehensive physical/well check_____/_____/___ Performed by PCP____________________________ or Someone else______________________

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

_____Asthma
_____Allergy
_____Tonsillitis
_____Seizures
_____Kidney Disease
_____Skin Problems
_____Chicken Pox
_____Major Injuries
_____Behavior Problems
_____Depression
_____Substance Abuse
_____Anxiety
_____ADHD
_____Heart Disease or Murmur
_____Ear or Sinus infections
_____Hearing and Speech Problems
______Endocrine (Diabetes, Thyroid, Pituitary)
______Infectious Disease (Hepatitis, HIV, TB, Meningitis)
______Missing Organ (Kidney, Eyes, Testicles)
______Blood Disorder or Birth Defects or Genetic Disorder
______Been Restricted from Sports/PE for Medical Reasons
______Vision Problems
______Other (specify) _________________________

Please describe any item marked: ____

FAMILY HISTORY:

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

_____Cancer
_____Asthma
_____Seizures
_____Allergy
_____Anemia
_____Depression
_____Substance Abuse
_____Anxiety
_____ADHD
_____Diabetes
_____Genetic Disorder
_____Sickle Cell
_____Heart Disease/Heart Problem
_____High Blood Pressure
_____Other (specify)___________________________
_____Stroke
_____Tuberculosis

Please describe any item marked (Who/When): ____