Health Centers in Schools
A Partner of Our Lady of the Lake Children's Health

General Consent for Treatment

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

I give my consent for my child, named above, to receive medical care from the school-based health program. I understand that as a participant the providers, the school nurse and your child's main health care provider may communicate by special video equipment with other physicians and health care professionals at other Health Care Centers in Schools' (HCCS) sites.

I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), healthcare student(s), and clinical staff to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science and acknowledge that no guarantees have been made to the patient named on this form.

Medical Education* I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty in accordance with organizational policies.

Photography and Other Recordings* I consent to photographs, audio and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in exam room.

Authorization for Healthcare-Related Calls, Texts and E-mails I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and also to e-mails using any e-mail address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

FMOLHS ATTN: Customer Service Team
5959 S. Sherwood Forest Blvd.
Baton Rouge, LA 70816

I agree that the services listed on page 3, unless noted in writing may be provided to my child.

I have completed the Patient Demographic Form (see page 4) and authorize Health Care Centers in Schools to bill Medicaid or other insurance providers for these services. I assign payments of authorized benefits directly to HCCS. I understand that I will not be charged for any of the services provided through the health center that are not covered by insurance.

I received a copy of the Health Care Centers in Schools "Notice of Privacy Practices". I understand that HCS has the right to change this notice at any time. I may obtain a current copy by contacting the administrative office of HCCS.

I understand that Health Care Centers in Schools programs may participate in one or more health information exchanges (HIEs), whereby the clinic may share my health information with other health care providers for treatment, payment, or health care operations purposes.

I also understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to School Based Health Clinic's (SBHCs) and, as part of such program; the Health Care Centers in School's Clinics are 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 health information exchanges (HIE) and consent to the disclosure of information to a HIE for such purpose. I understand that the School Based Health Clinic (SBHC) may participate in one or more HIEs, whereby the clinic 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.

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.

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 Care 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 **HCCS**.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO THE FOLLOWING SERVICES FOR YOUR CHILD:

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

• Primary and preventive health care (including immunizations) • Comprehensive history and physical examinations health screenings • Laboratory/diagnostic testing • Case management • Acute care for minor illness/injury (including medications), if indicated • Hearing & Vision screening	• 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:

_____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.

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL SERVICES OFFERED, EXCEPT THOSE WHICH I HAVE WRITTEN HERE:

_____
_____
_____
_____
_____
_____
_____

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.

We also understand that the school-based health center/school nurse program is operated by **OLOL Children's Health Care Centers in Schools** and its employees/contractors and not by the local schoolboard.

By signing below, I acknowledge that I have read this form, and fully understand and accept its terms andconditions. I have had a chance to ask any questions that I might have.

Patient Name (print): _____

Patient Signature: _____

Date**:** _____ **Time:** _____

If the patient is a minor, the person authorized to consent should sign below.

Authorized Person for Consent Name (print): _____

Authorized Person for Consent Signature: _____

Date: _____ **Time:** _____

If the patient is not a minor, but is unable to consent, the person authorized to do so should sign below. **Authorized**

Person for Consent Name (print): _____

Authorized Person for Consent Signature: _____

Date: _____ **Time:** _____

LOUISIANA ENROLLMENT DEMOGRAPHIC FORM FOR HEALTH CARE CENTERS IN SCHOOLS (HCCS) SCHOOL-BASED & MOBILE HEALTH SERVICES

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:	Parent/Guardian's Email:		Student's 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 Doctor/ Provider:				Phone: ( )
Student's Dentist:				Phone: ( )

Preferred Pharmacy (Name, Street and Phone Number must be entered)

Please check the type of health insurance your child has:

❑ Medicaid/Healthy Louisiana Plan#:_____(check one below)

❑ Healthy Blue ❑ AmeriHealth Caritas LA ❑ Aetna Better Health of LA

❑ LA Healthcare Connections ❑ United Healthcare Community Plan

❑ Medicaid (dental) #: _____

❑ No insurance

Please attach a copy of insurance card (front and back).

❑ Private/Other Insurance Employer 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

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? Medicine? Insects? 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	_____Behavior Problems	_____Endocrine (Diabetes, Thyroid, Pituitary)
_____Allergy	_____Depression	_____Infectious Disease (Hepatitis, HIV, TB, Meningitis)
_____Tonsillitis	_____Substance Abuse	_____Missing Organ (Kidney, Eyes, Testicles)
_____Seizures	_____Anxiety	_____Blood Disorder or Birth Defects or Genetic Disorder
_____Kidney Disease	_____ADHD	_____Been Restricted from Sports/PE for Medical Reasons
_____Skin Problems	_____Heart Disease or Murmur	_____Vision Problems
_____Chicken Pox	_____Ear or Sinus infections	_____Other (specify) _____
_____Major Injuries	_____Hearing and Speech Problems	_____

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

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