PRIME TIME

HEAD START

*To complete this **application online**, go to **https://primetimefamily.org/head-start-ouachita/** and click on **"Register"**.*

2021-2022 TAKE-AWAY APPLICATION

Go ahead and DOWNLOAD/SAVE this document to your *DESKTOP* or *MY DOCUMENTS* folder.

Updated: 7.28.20, 8.31.21, 11.5.21

Dear Parent or Guardian:

Thank you for your interest in the PRIME TIME Head Start program. To apply for our program, please provide a copy of the following documents.

Your application is incomplete without all required documents.

Proof of Income for the last 12 months (Bring ALL that apply):

-W-2	-1 month of pay stub(s)	-Child Support
-Social Security	-Utility assistance	-Employment offer letter
-TANF/FITAP award letter	-SSI award letter	-Written statement from employer
-SSD or SSA	-VA assistance	-Student Loan/Aide with class schedule

For families with ZERO income, a ***Zero Income Statement Form*** will be provided.

Documentation of Date of Birth (only one is needed): Birth certificate, passport, or immigration card

- Child must be minimum of 3 years old before September 30th
- Child cannot be kindergarten eligible.

Proof of Residence (only one is needed): Utility bill(s), lease or rental agreement

Parent/Guardian Identification: State ID, State issued driver's license, military ID

----------What's next? ----------

Please note that if your child is selected for our program, you must provide the following **prior to entry into the classroom**:

Insurance Cards: Medical and Dental (if available)

Immunization Record(s)

Physical Exam/Well-Visit form signed by physician

Doctor's report or Universal Child Health Record (attached), showing a physical exam within the last 12 months.

- Blood tests (hemoglobin/hematocrit, lead)
- Vision, and Hearing screenings

Dental Exam documentation completed within the last 12 months

If your ***child has special needs***, the following documentation may be needed:

-Care Plan signed by physician	-Individual Care Plan signed by physician
-Medication Administration Form	-Medical Statement for Food Substitutes provided by physician
-IFEP or IEP	-Disability Evaluations/Results

If you need any assistance getting the required information or completing the application, please contact us at (318) 541-2315.

Sincerely,
PRIME TIME Head Start

Updates: 8/30/2019, 6/17/2020

Office Use only:

OPENetwork Coordinated Application 2021-2022

Placed_____ Not Placed_____

Your Choices Shape Their Chances

STUDENT'S NAME_____
FIRST MIDDLE LAST

◯ MALE ◯ FEMALE AGE:_____ DATE OF BIRTH:_____ Home Language:_____

# of Parents/Guardians & Children in Home: _____ **# of children in home:** _____

Have You Applied for CCAP? Yes ☐ No ☐ _____
Date Application Completed

Are You Approved for CCAP? Yes ☐ No ☐
Are You on the CCAP Waitlist? Yes ☐ No ☐

Does the child have a current IEP or IFSP? (Child is receiving services through the school system or Early Steps)
◯ Yes ◯ No
Concern/Diagnosis:_____

1. PARENT/LEGAL GUARDIAN living in home WITH Child **RELATIONSHIP to CHILD:**_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE:_____**EMAIL:**_____

2.PARENT/LEGAL GUARDIAN living in home WITH child **RELATIONSHIP TO CHILD:**_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE:_____**EMAIL:**_____

How did you learn about the participating programs and eligibility? _____

ALTERNATE CONTACT

1. CONTACT NAME:_____ **PHONE#:**_____**RELATIONSHIP:**_____

2. CONTACT NAME:_____ **PHONE#:**_____**RELATIONSHIP:**_____

Ranking	Program (see flyer for all Programs)	Types (Circle One)	Brother or Sister in program
1st Choice		◯ Childcare ◯ Headstart ◯ School	◯ Yes ◯ No
2nd Choice		◯ Childcare ◯ Headstart ◯ School	◯ Yes ◯ No
3rd Choice		◯ Childcare ◯ Headstart ◯ School	◯ Yes ◯ No
* If your 1st choice does not have available seats, this does not guarantee enrollment in your 2nd choice program.			

Parent/Guardian permission for information sharing

I, the undersigned, understand that sharing the information I have provided in this application across early childhood programs in my community will facilitate matching my child to a seat, and I hereby give permission for the information provided here to be shared with the programs/Lead Agency in theOPENetwork._____

Signature (parent or legal guardian) **Date**

STUDENT'S NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

Child's Parental/Guardian Status: ◯ One parent household ◯ Two parent household

Child's Race: ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Hawaiian/Pacific Islander ☐ Other:_____

Child's Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Child's Nationality:** ☐ American ☐ Canadian ☐ Other:_____

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1. PARENT/LEGAL GUARDIAN *continued from page 1*

NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

Primary adult caring for child? ☐ Yes ☐ No **Custody of the child?** ☐ Yes ☐ No

Phone Number with area code *(Please provide more than 1 number with at least one cell number if possible.)*	**Primary Phone?**	**Phone Type**	**When NOT to call**	**Can receive TEXT messages?**
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	Other: _____		☐ Yes ☐ No

TEEN parent (19 or younger) at the time of child's birth? ☐ Yes ☐ No

Parent/Guardian lives with the child most of the time? ☐ Yes ☐ No

Specific Relationship to child ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Niece/Nephew ☐ Other: _____

English level ☐ Advanced/Proficient ☐ Moderate ☐ Poor ☐ None

HIGHEST Education Level ☐ High School Diploma ☐ GED/HiSet ☐ less than grade 9 ☐ grade 9 ☐ grade 10 ☐ grade 11 ☐ grade 12 ☐ Some College ☐ Specialized Certificate ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree

Employment Status (check all that apply): ☐ Currently Unemployed ☐ Full Time (35+ hrs.) ☐ Part Time ☐ Disabled ☐ Training or in School ☐ Retired ☐ Seasonally Employed ☐ Multiple Periods of Unemployment over the past 5 years

2. PARENT/LEGAL GUARDIAN *continued from page 1*

NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

Primary adult caring for child? ☐ Yes ☐ No **Custody of the child?** ☐ Yes ☐ No

Phone Number with area code *(Please provide more than 1 number with at least one cell number if possible.)*	**Primary Phone?**	**Phone Type**	**When NOT to call**	**Can receive TEXT messages?**
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	☐ Home ☐ Cell ☐ Work		☐ Yes ☐ No
	☐ Yes ☐ No	Other: _____		☐ Yes ☐ No

TEEN parent (19 or younger) at the time of child's birth? ☐ Yes ☐ No

Parent/Guardian lives with the child most of the time? ☐ Yes ☐ No

Specific Relationship to child ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Foster Child ☐ Grandchild ☐ Niece/Nephew ☐ Other: _____

English level ☐ Advanced/Proficient ☐ Moderate ☐ Poor ☐ None

HIGHEST Education Level: ☐ High School Diploma ☐ GED/HiSet ☐ less than grade 9 ☐ grade 9 ☐ grade 10 ☐ grade 11 ☐ grade 12 ☐ Some College ☐ Specialized Certificate ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree

Employment Status (check all that apply): ☐ Currently Unemployed ☐ Full Time (35+ hrs.) ☐ Part Time ☐ Disabled ☐ Training or in School ☐ Retired ☐ Seasonally Employed ☐ Multiple Periods of Unemployment over the past 5 years

ADDITIONAL HOUSEHOLD MEMBERS

ADDITIONAL HOUSEHOLD MEMBERS who live in the home, are supported by the parent/guardian's income, and are related to the parent/guardian by blood, marriage, or adoption.

First and Last Name	Relationship to Child	Date of Birth

Total # of people *(including the child, adults listed on page 1, and the additional household members listed above)* **who live in the child's household and are part of his/her family?** _____

*TIME TO **HIT THAT SAVE** BUTTON!*

CHILD'S NEEDS

Does child have a disability (diagnosed by a doctor or specialist)? ☐ Yes ☐ No

If yes, what is the specific disability? _____

Does child receive any special education services? ☐ Yes ☐ No

Does he/she have an IEP or IFSP? ☐ Yes ☐ No

Do you have any concerns about child in any of the areas listed below? If YES, please check appropriate item(s).

☐ Hearing ☐ Vision ☐ Environmental Allergies ☐ Food Allergies ☐ Asthma ☐ Dental Problems ☐ Overweight

☐ Underweight ☐ Seizures ☐ Anemia ☐ High Lead levels ☐ Diabetes

☐ Other medical/dental/nutrition concern not listed above: _____

☐ Other developmental concern not listed above: _____

☐ Other speech/language development concern not listed above: _____

☐ Other behavior/emotional concern not listed above: _____

☐ **(Only check if NO CONCERNS are listed above.)** I have reviewed the concerns listed above, and child has NO NEEDS listed above at this time.

FAMILY NEEDS

Is your family living with *(check all that apply, if any)*: ☐ drug abuse? ☐ alcohol abuse? ☐ incarceration?

☐ child support issues? ☐ domestic violence? ☐ serious health issue? ☐ mental health issue? ☐ None apply to our family.

SERVICES: What services are your family receiving?

Family is receiving OR has received services from DCFS? ☐ Yes ☐ No

☐ Food Stamps (SNAP) ☐ Housing Services (Public Housing, Section 8) ☐ State Health Insurance ☐ WIC

☐ Foster Care/Adoption Subsidy ☐ Utility/Energy Assistance ☐ Child Support ☐ Privat Health Insurance

☐ Health Services ☐ Mental Health Services ☐ Emergency/Crisis Intervention

Social Services from another agency? ☐ Yes ☐ No If yes, which one?_____

Do you currently have a caseworker at another agency? ☐ Yes ☐ No If yes, which agency?_____

☐ NONE OF THE ABOVE

Do you currently receive TANF? ☐ Yes ☐ No **or SSI?** ☐ Yes ☐ No

Are you HOMELESS? ☐ Yes ☐ No **Have you RELOCATED 2 or more times in the past year?** ☐ Yes ☐ No

Do you currently receive a Child Care Subsidy/Voucher? ☐ Yes ☐ No ☐ Don't know ☐ Not eligible

LEGAL ISSUES

Is your family currently dealing with legal issues such as (check all that apply, if any)

☐ Family Court? ☐ Divorce? ☐ Custody? ☐ Probation? ☐ Restraining order(s)? ☐ Incarceration?
☐ Other: _____? ☐ NO, my family has no legal issues.

If you checked any legal issues above, please clarify. _____
_____

Have you ever been displaced from home due to a hardship? ☐ Yes ☐ No

Has your child ever been in Foster or Kinship Care? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Has your child previously been enrolled in an Early Head Start ☐ Yes ☐ No
If yes, which one? _____

Has your child previously been enrolled in a Head Start ☐ Yes ☐ No
If yes, which one? _____

Has your child previously been enrolled in a Preschool Program ☐ Yes ☐ No
If yes, which one? _____

Are YOU or a FAMILY MEMBER a staff member of Prime Time Head Start ☐ Yes ☐ No
If yes, who? _____

Has your child had a sibling previously enrolled in the Prime Time Head Start program? ☐ Yes ☐ No
If yes, is he/she currently enrolled? ☐ Yes ☐ No Specify dates of attendance: _____ to _____

How did you hear about Prime Time Head Start? ☐ Word of mouth (friend/family) ☐ Flyer/Poster ☐ Billboard

☐ Facebook ☐ Bus bench ☐ Radio ☐ Someone who works at Prime Time Head Start

☐ Referred by an agency (WIC, Children's Coalition, child support services, DCFS, child care subsidy, other)?
Specify agency: _____

☐ OTHER resource not listed: _____

PARENT/GUARDIAN SIGNATURE NEEDED

I verify that I completed this application and provided true information.

Print Parent/Guardian Name: _____

Typing your First and Last Name in the Signature Block below, acts as your signature.

Signature of Parent/Guardian: _____ Date: _____

OFFICE USE ONLY

Date Application Received: _____ Received by: _____

Date Entered in Shine Insight: _____ Entered by: _____

*TIME TO **HIT THAT SAVE** BUTTON!*

PRIME TIME HEAD START

Emergency Contact Information

Child Name:______________________________________Date of Birth:____________________________

Address Lives At:____

Parent/Guardian 1:____Relationship to child:_______________

Home Address (if different):____

Work Address: ____

Home Phone:___________________Cell Phone:_________________Work/Other: ________________

Parent/Guardian 2:____Relationship to child:_______________

Home Address (if different):____

Work Address: ____

Home Phone:___________________Cell Phone:_________________Work/Other: ________________

Authorized Contacts –*Please provide information for at least 2 people who are permitted to pick up your child from the Prime Time Head start program, and whom we can contact if necessary in an emergency. Please note that we must have a letter on file that documents our agreement to have an authorized contact under 18 years of age pick up your child. Please note that your child* ***will not*** *be released to anyone not on this list.*

Name: ____

Relationship to child: _________________________________

Home Address: _____________________________________

City: ____________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: _________

Staff Initials: ___________________ Date: ______________

Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________

Name: ____

Relationship to child: _________________________________

Home Address: _____________________________________

City: ____________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: _________

Staff Initials: ___________________ Date: ______________

Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________

Name: ____

Relationship to child: _________________________________

Home Address: _____________________________________

City: ____________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: _________

Staff Initials: ___________________ Date: ______________

Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________
Removed on: _______	By:____________	Staff: ___________
Added Back: _______	By:____________	Staff: ___________

Is there a court order in place that restricts anyone from picking up your child? (Non-custodial parent or other adult due to restraining order, child' s foster or kinship status, etc) Yes:☐______________No:☐_If yes, please provide Prime Time Head Start with documentation, such as a copy of a court order to maintain in file and provide updates as needed

NAME:______________________________________RELATIONSHIP TO CHILD: ______________________________

Is there any other person who may try to pick up your child who is not authorized to do so (i.e. but for whom there are no court papers)? If so, please give NAME:______________________________RELATIONSHIP TO CHILD:________________

Parent Signature: ______________________________ ***Date:*** _______________

Typing your First and Last Name in the Signature Block above, acts as your signature.

PRIME TIME HEAD START

Emergency Contact Information

Child Name:______________________________________ Date of Birth:______________________________

Address Lives At:____

Additional Contacts

Name: ____

Relationship to child: ____________________________________

Home Address: _______________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: __________ Cell: __________ Other: __________

Staff Initials: ___________________ Date: ________________

Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________

Name: ____

Relationship to child: ____________________________________

Home Address: _______________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: __________ Cell: __________ Other: __________

Staff Initials: ___________________ Date: ________________

Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________

Name: ____

Relationship to child: ____________________________________

Home Address: _______________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: __________ Cell: __________ Other: __________

Staff Initials: ___________________ Date: ________________

Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________

Name: ____

Relationship to child: ____________________________________

Home Address: _______________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: __________ Cell: __________ Other: __________

Staff Initials: ___________________ Date: ________________

Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________

Name: ____

Relationship to child: ____________________________________

Home Address: _______________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: __________ Cell: __________ Other: __________

Staff Initials: ___________________ Date: ________________

Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________
Removed on: _______	By:_____________	Staff: _____________
Added Back: _______	By:_____________	Staff: _____________

Parent Signature: ______________________________ ***Date:*** ________________

Typing your First and Last Name in the Signature Block above, acts as your signature.

PRIME TIME HEAD START

Permission for Program Activities

STUDENT'S NAME_____

FIRST MIDDLE LAST DATE OF BIRTH

To help us provide your child with the highest-quality services, Prime Time needs your permission for the activities listed below. **For each item, please check YES or NO.**

1. I give permission for my child to participate in **walking trips** within the Prime Time center neighborhood, including to local parks or playgrounds. *I understand that children will not enter any other facility unless I am informed in writing in advance; that the route will avoid all safety hazards, and that there will always be an adult-child ratio in keeping with licensing requirements.* ☐ YES ☐ NO

2. I give permission for my child to be **photographed and/or videotaped while** participating in Prime Time program activities, and for these photos or videos to be used in newsletters, displays, or other formats for educational purposes or program publicity including social media. ☐ YES ☐ NO

3. I give my permission for me to be **photographed or videotaped** during program activities in order to support *Prime Time's* staff development activities. I understand that these photographs and videotapes will not be used for any other purposes without my additional consent. ☐ YES ☐ NO

4. I understand that as part of the program, staff and consultants engage in regular observations and assessments of children's progress toward achieving school readiness skills in order to individualize our instruction to best support them, and to improve our program as a whole. In addition to these educational assessments, I give permission for my child to receive the following screenings, that are required of all Head Start programs, and that will help Prime Time Head further understand his/her development and provide the best possible learning environment for his/her strengths and needs:

   Health Screenings – hearing, vision, height, weight, blood iron, blood pressure, lead, dental ☐ YES ☐ NO

   Developmental Screening – to identify child's stages of development and possible areas of delay ☐ YES ☐ NO

   Social-Emotional Screening – to identify possible areas of mental health concern ☐ YES ☐ NO

   Speech Screening – to identify any concerns regarding child's language development ☐ YES ☐ NO

5. I give permission for staff to conduct **focused observations** of my child in his/her classroom so that *Prime Time* can better **understand his/her development, challenges and needs**. I understand that I will be notified of pending observations and will be invited and encouraged to participate in all related conversations and next steps. ☐ YES ☐ NO

6. I give permission for my child to have the above screenings, and other program components as needed, administered in his/her own language by an **interpreter** chosen by Prime Time Head Start. ☐ YES ☐ NO

7. **Prime Time wants to send you text messages!** These text messages could include FUN FACTS and EASY Tips to help support your child's learning, attendance and health follow-up, meeting and event reminders and notifications about school closings and delays. You can choose to stop receiving texts at any time by replying STOP to any message. I give permission for Prime Time Head Start to text me regarding my child's learning and program participation. ☐ YES ☐ NO

Parent/Guardian Name:_____ **Relationship to Child:**_____

Parent/Guardian Signature:_____ **Date:** _____

Typing your First and Last Name in the Signature Block above, acts as your signature.

*TIME TO **HIT THAT SAVE** BUTTON!*

You are doing great! If you get stuck, just give us a call at (318)541-2315.

At Prime Time Head Start, we want your family to be **safe and healthy.**

Please take your time with this next section.

KEEP GOING…

PRIME TIME HEAD START

Emergency Consent:
Authorization for Medical Care for Minor Child

Child Name: _____ Date of Birth: _____

In the event of an emergency affecting your child, **PRIME TIME® Head Start** will make every attempt to contact you. In unusual circumstances, however, we might need to act immediately to protect your child. **We need your permission to do so.** *Please initial next to each item, then sign below.*

T***yping your INITIALS*** in the lines provided, is the same as ***signing your initials.***

1. I give permission to **PRIME TIME® Head Start to** take emergency measures (e.g. first aid, disaster evacuation) as judged necessary for the care and protection of my child while under the supervision of the center. *Initials:* _____

2. I give permission for my child to receive X-rays, examinations, anesthesia, and/or medical, surgical or dental treatment and care, under the supervision of a licensed physician, dentist or surgeon, when the need for such treatment is immediate and I cannot be reached. *Initials:* _____

3. In case of a medical emergency, I give permission for my child to be transported to an appropriate medical facility for treatment if the local emergency resources (police, rescue squad, ambulance) deem it necessary. I understand that these transportation expenses will be my responsibility as the child's parent/guardian. *Initials:* _____

4. In the event that my child's center needs to be evacuated, I give permission for my child to be transported to another nearby location. I understand that I will be informed by telephone at the earliest possible opportunity. *Initials:* _____

5. I understand that in some medical situations, the staff will need to contact the local emergency resources before the parent, child's physician, and/or other adults acting on the parent's behalf. *Initials:* _____

This form must be signed by the child's parent or legal guardian.

Signature _____ **Date** _____

Print Name _____ **Relationship to Child** _____

Typing your First and Last Name in the Signature Block above, acts as your signature.

To be completed by: **PRIME TIME® Head Start**

Physician Name: _____ Phone Number: _____

Dentist Name: _____ Phone Number: _____

Allergies: _____

Medical condition(s) that could be relevant in an emergency: _____

_____

Signature of Staff: _____ Date: _____

The original will be kept in the child's file with a copy of this form in the classroom.

PRIME TIME HEAD START

CENTER: MLK RAN ROB TW

Child Health and Nutrition History

STUDENT'S NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

PARENT/GUARDIAN NAME_____
FIRST LAST

STAFF NAME_____ **Initials:** _____ **Date:** _____
FIRST LAST

HEALTH OVERVIEW AND SOURCE OF CARE

Child's last PHYSICAL exam Date: _____ Physician/Clinic:_____

Child's last DENTAL exam Date: _____ Dentist/Clinic:_____

Child's INSURANCE: ☐ Medicaid ☐ State Insurance ☐ No Insurance ☐ Private

Child's Policy Number (if applicable): _____

Family insurance status: ☐ Entire family insured–**Skip to EARLY Child Health Concerns** ☐ Entire family uninsured
☐ Guardian(s) uninsured Please explain: _____

Family insurance eligibility: ☐ Entire family eligible ☐ Entire family ineligible ☐ Guardian(s) ineligible
☐ Other child(ren) ineligible Please explain: _____

If uninsured, do you and/or the child's siblings access medical and dental care through free or low-cost clinics? ☐ Yes ☐ No Comment: _____

EARLY CHILD HEALTH CONCERNS

Concerns	**Explain any "YES" answers**
Did mother have any **problems during pregnancy**? ☐ Yes ☐ No Child's birth weight:_____lb_____oz	
Has child ever been **hospitalized or operated on**? ☐ Yes ☐ No Had a **serious illness**? ☐ Yes ☐ No Had a **serious accident or broken bone**? ☐ Yes ☐ No	
Does your child need help or have trouble with **toileting**? ☐ Yes ☐ No	
Does your child **sleep** less than 8 hours at night? ☐ Yes ☐ No Does your child nap? ☐ Yes ☐ No	About how many hours per night? Time of day/length of nap?
At what age did your child start **walking/talking**?	Age in months when started to walk? Age in months when started to talk?
Was your child **born pre-mature** (before 37 weeks)? ☐ Yes ☐ No	Born at how many weeks? Reason?

CHILD HEALTH CONDITIONS

Concerns	Explain any "YES" answers
Is a physician or dentist **currently treating** child for **any concerns or special conditions?** ☐ Yes ☐ No	If so, what conditions?
Does child have, or ever had, any of the following? (check ALL that apply) ☐ Asthma ☐ Bleeding Tendencies ☐ Anemia ☐ Diabetes ☐ Heart/Blood Vessel Disease ☐ Sickle Cell Disease ☐ Liver Disease ☐ Under/overweight ☐ High Lead ☐ Convulsion/seizure – if yes: was it related to a high fever? ☐ Yes ☐ No ☐ Other: _____	Explain checked conditions. If checked, date of last convulsion/seizure?
Is child **taking medication**? ☐ Yes ☐ No *If yes, list medication(s):* _____ _____	Reason:
VISION QUESTIONS: Do you have any concerns about child's **ability to see**? ☐ Yes ☐ No Do you have any concerns about the way child **looks at you** (or at **books, or how he/she watches TV**)? ☐ Yes ☐ No Has your child ever been **referred to, or seen by an eye doctor**? ☐ Yes ☐ No	Name of Eye Doctor: Date of last visit: Other Details:
HEARING QUESTIONS: Does child have **trouble with ears/hearing**? (e.g., pain in ear, frequent earaches, infections, drainage, hearing loss) ☐ Yes ☐ No Do you have any concerns about **the way child responds when you talk** to him/her? Or, how he/she is learning to talk? ☐ Yes ☐ No Did child have **newborn hearing screening** done in the hospital? ☐ Yes ☐ No **If yes**, what were the results? ☐ Pass ☐ Fail Has your child ever been **referred to, or seen by an ENT or Audiologist**? ☐ Yes ☐ No	Name of Doctor: Date of last visit: Other Details:

Any significant changes should be shared with appropriate staff and documented in Shine Insight.

CHILD DENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have any **trouble with teeth, gums, chewing/ eating or mouth**? ☐ Yes ☐ No	
Does child currently receive (check ALL that apply): ☐ Topical fluoride application ☐ Fluoridated water ☐ Fluoride supplement (tablets) ☐ Fluoride supplement (liquid)	**If yes**, how long has child been receiving fluoride?

CHILD ALLERGY AND NUTRITION CONCERNS

CONCERNS	Explain any "YES" answers
1. Does child have any **allergy problems** (e.g., rash, itching, swelling, difficulty breathing)? ☐ Yes ☐ No **If yes**, is allergy related to (check ALL that apply): ☐ Medication ☐ Food ☐ Animals/fur ☐ Insects/dust ☐ N/A or None **Has allergy ever required emergency medical care?** ☐ Yes ☐ No	If yes, describe reaction. Does child have an EpiPen Jr. or other medication? Describe. Describe reason for emergency care?
FOOD/SPECIAL DIET NEEDS: 2. Does your child have a: ☐ Yes ☐ No Food allergy? ☐ Yes ☐ No Food Intolerance? ☐ Yes ☐ No Medical need for a food restriction ☐ Yes ☐ No Religious food restriction	Describe: If food/diet related, list food item(s).
3. Does your child currently have **problems chewing or swallowing foods or liquids**? ☐ Yes ☐ No	Describe concern:
4. Do you have concerns about your **child's size, what he/she eats or feeding behaviors**? ☐ Yes ☐ No **If yes**, would you like to meet with the Nutritionist? ☐ Yes ☐ No	Describe concern:
Child currently takes/uses (Check ALL that apply): ☐ Bottle ☐ Sippy Cup ☐ Drinking Cup ☐ Drinking Straw	If yes, how often?

==========STAFF NOTE==========

If any questions from 1 through 3 answered YES in the *Child Allergy and Nutrition Concerns*, refer to Nutritionist.

CHILD ABILITIES AND DEVELOPMENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have a diagnosed disability, with an **IEP or IFSP**? ☐ Yes ☐ No	Describe
Do you have any **Developmental Concerns** in any of the following areas? ☐ None ☐ Speech or language ☐ Physical Development ☐ Behavior/emotional ☐ Other:	Describe

CHILD TB RISK ASSESSMENT

RISKS	Explain any "YES" answers
Was your **child born in** Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? ☐ Yes ☐ No	**If yes,** in what country was the child born?
Has your **child lived or traveled in** Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? ☐ Yes ☐ No	**If yes**, what country? For how long?
In the **last 2 years, has your child lived with or spent time with** someone **who has been sick with TB**? ☐ Yes ☐ No	**If yes,** please explain:
Does your child have **any history of immunosuppressive disease or take medications that might cause immunosuppression**? ☐ Yes ☐ No	**If yes,** please explain:

==========STAFF NOTE==========
Any YES answers above in *TB Assessment* section, should be referred to Health team.

FAMILY SMOKING ASSESSMENT

1. Does your **child live with anyone who smokes**? ☐ Yes ☐ No
2. Does **anyone ever smoke in your home or car**? ☐ Yes ☐ No

If yes to either question 1 or 2 above, who smokes? _____

3. Do you currently smoke? ☐ Yes ☐ No, I quit less than a year ago. ☐ No, I have never smoked.

IF you answered NO to #3, skip the following 2 questions in this section.

4. If you smoke, **how interested are you in quitting**? ☐ Very interested ☐ A little interested ☐ Not interested
5. Do you want to learn of free ways to help you quit? ☐ Yes ☐ No ☐ I am not sure.

Any significant changes should be shared with appropriate staff and documented in Shine Insight.

*TIME TO **HIT THAT SAVE** BUTTON!*

Let's talk food and nutrition!

**Please complete the CACFP Enrollment form on the next page (18).

A) IF your child has a FOOD ALLERGY or special diet, please complete page 19.

B) If your child DOES NOT have a food allergy or special diet, please complete page 18 (skipping 19) and move on to page 20.

CACFP ANNUAL ENROLLMENT FORM

October 1, 20___ to September 30, 20___

Directions: To be completed by the parent/guardian as indicated. Complete a separate form every year for each child in the household who does not have a completed F/RP Meal Application (CACFP 106) on file. If enrolled in the Head Start Program, the participant must meet the criteria prescribed under the Head Start Act to automatically qualify for "Free" meal benefits and therefore is exempt from completing a Free/Reduced Price Meal Application. Documentation of enrollment must be updated annually, signed by a parent or legal guardian, and includes information on each child's normal days and hours of care and expected meal participation. [Reference: 7 CFR 226.17(b)(8)]

INSTITUTION NAME/ADDRESS:
Prime Time, Inc.
(PRIME TIME® Head Start)
938 Lafayette Street, Suite 300
New Orleans, LA 70113
(504) 523-4352

CENTER NAME/ADDRESS (circle one):

Ransom Head Start	Robinson Head Start	MLK Head Start	Thomas & Wilson Head Start
420 Wheelis St.	5307 Robinson Place	3716 Nutland Rd,	1111 Thomas & Wilson St.
W. Monroe, LA	Monroe, LA 71202	Monroe, LA 71202	Monroe, LA 71201
71292	(318) 855-1826	(318) 737-2169	(318) 361-3801
(318) 855-1392			

Child's Name: _____ DOB: _____(mm/dd/yyyy)

Please indicate the normal days and hours of expected care for participant listed above. Check all that apply and list hours below (Days, hours and meal types may vary based on actual participation.):

Expected days of participation: __X__ Monday __X__ Tuesday __X__ Wednesday __X__ Thursday __X__ Friday

Expected hours of participation: From ___7:40 AM_____ To _____2:50 PM_____

Expected meal participation (check all that apply): __**X**__ Breakfast __**X**__ Lunch __**X**__ Snack

List any allergies to foods or beverages: _____
(Write "NONE" if child has no allergies.)

Parent/Guardian's Name: _____ _____
(PRINT) (SIGN)
Date: _____

Address: _____ Phone Number: _(____)_____
(Street Address, City, State, Zip Code)

This institution is an equal opportunity provider.

For Official Use Only:
Eligibility Determination: **FREE**
Determining Official's Signature: _____ Date: _____

SKIP if NO ALLERGIES or SPECIAL DIETS needed.

19

Medical Statement for Food Substitutions
Complete Part A OR Part B

STUDENT'S NAME_____
FIRST LAST Date of Birth Current Age

CENTER: MLK Ransom Robinson Thomas & Wilson _____ _____
(Circle one) CLASS # TEACHER(s)

PARENT/GUARDIAN NAME_____ _____
FIRST LAST Relationship to Child

PART A: MEDICAL PROVIDER ONLY

Does this participant have a disability? ☐ Yes ☐ No
If yes, describe major life activities affected by the disability. _____

Does the participant have **special nutritional or feeding needs** related to the disability? ☐ Yes ☐ No

Identify the **medical need for a special diet**: _____

List all foods to be omitted from the child's diet: _____
_____

Does the child require a **Lactose Free Milk Substitute**? ☐ Yes ☐ No
If yes, any specific kind/suggestions? _____

Does the child require a **Milk FREE Substitute**? ☐ Yes ☐ No
If yes, any specific kind/suggestions? ☐ Soy Milk ☐ Rice Milk ☐ Other: _____

WHOLE or BOTH WHOLE & PROCESSED? Please designate whether the food restriction refers to the whole form of the food or both the whole form plus the food found in processed foods.
EXAMPLE: whole eggs or whole eggs plus processed foods containing eggs

☐ Whole form of food
☐ Whole form of food PLUS food found in processed foods

Does the child require **medication on site for a food allergy or intolerance**? ☐ Yes ☐ No
If yes, Name of Medication(s): _____
(Medication Authorization Required)

Physician, RD or RN signature: _____ Date: _____

PART B: PARENT/GUARDIAN ONLY

Please list all foods you would like to be eliminated from your **child's diet for religious reasons**.

☐ No religious restrictions ☐ Yes, please restrict: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian must always sign this form Updated: 7/11/20

Fax form to (318) 737-2005 or email to enroll@primetimefamily.org

ALMOST DONE!

Does your child have a Primary Care Physician (regular doctor, nurse practitioner, etc.)?

YES	Yes, but I can't get him/her there.	NO
1. Make a well-child appointment with his/her primary care physician. 2. PRINT the next page, the *Universal Child Health Record,* on ***page 21*** and take it with you to the appointment. 3. Return the form to Prime Time Head Start.	No problem! Complete the consent forms starting on page 23.	We can help! Complete the consent forms starting on page 23.
	Completing pages 23-36 gives our 3 local health services partners permission to perform physical and dental exams at our sites at **NO COST** to you. This does not replace your primary care physician. Our 3 local health services partners are: • Primary Health Services Center, • CommuniHealth, and • Dr. Turner.	

Does your child have a Primary Dentist?

YES	Yes, but I can't get him/her there.	NO
1. Make a dental appointment with his/her dentist. 2. PRINT the *Head Start Oral Form,* on ***page 22*** and take it with you to the appointment 3. Return the form to Prime Time Head Start.	No problem! Complete the consent forms starting on page 23	We can help! Complete the consent forms starting on page 23.
	Completing pages 23-36 gives our 3 local health services partners permission to perform physical and dental exams at our sites at **NO COST** to you. This does not replace your primary care physician. Our 3 local health services partners are: • Primary Health Services Center, • CommuniHealth, and • Dr. Turner.	

If you have BOTH a PRIMARY CARE PHYSICIAN and a PRIMARY DENTIST and are able to have both doctors complete forms on pages 21 and 22, please proceed to page 37.

UNIVERSAL
CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child s Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐ Yes ☐ No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child s Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐ Yes ☐ No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐ Yes ☐ No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if >3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)

Health Care Provider Stamp:

Signature/Date

Email form to enroll@primetimefamily.org or fax to (318) 737-2005.

Early Childhood National Centers
NATIONAL CENTER ON
Early Childhood Health and Wellness

Email completed form to enroll@primetimefamily.org or fax to (318) 737-2005.

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ○ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ○ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ○ Yes ○ No

Are there treatment needs? ☐ Yes, urgent ○ Yes, not urgent ○ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ○ No
X-rays: ☐ Yes ○ No
Risk assessment: ☐ Yes ○ No
Cleaning: ☐ Yes ○ No
Fluoride varnish: ☐ Yes ○ No
Dental sealants: ○ Yes ○ No

Counseling/Anticipatory Guidance

☐ Yes ○ No

Referral to Specialty Care

☐ Yes ○ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ○ No
Crowns: ○ Yes ○ No
Extractions: ☐ Yes ○ No
Emergency care: ☐ Yes ○ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ○ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ○ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #9OHC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.

LHSAA MEDICAL HISTORY EVALUATION

DR. TURNER CONSENT FORM

IMPORTANT: This form must be completed *annually*, kept on file with the school, & is subject to inspection by the Rules Compliance Team.

Please Print

Name:_____School: ***Prime Time Head Start*** Grade: ***Pre-K*** Date:_____

Sport(s):_____Sex: M / F Date of Birth:_____Age:_____Cell Phone:_____

Home Address:_____City:_____State:____ Zip Code:_____Home Phone:_____

Parent / Guardian:_____Employer:_____Work Phone:_____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease	_____	☐	☐	Sudden Death	_____	☐	☐	Arthritis	_____
☐	☐	Stroke	_____	☐	☐	High Blood Pressure	_____	☐	☐	Kidney Disease	_____
☐	☐	Diabetes	_____	☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Epilepsy	_____

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion	_____	☐	☐	Neck Injury / Stinger	_____	☐	☐	Shoulder L / R	_____
☐	☐	Elbow L / R	_____	☐	☐	Arm / Wrist / Hand L / R	_____	☐	☐	Back	_____
☐	☐	Hip L / R	_____	☐	☐	Thigh L / R	_____	☐	☐	Knee L / R	_____
☐	☐	Lower Leg L / R	_____	☐	☐	Chronic Shin Splints	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____	☐	☐	Pinched Nerve	_____
☐	☐	Chest	_____	Previous Surgeries: _____							

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Murmur / Chest Pain / Tightness	☐	☐	Asthma / Prescribed Inhaler	☐	☐	Menstrual irregularities: Last Cycle:_____
☐	☐	Seizures	☐	☐	Shortness of breath / Coughing	☐	☐	Rapid weight loss / gain
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Take supplements/vitamins
☐	☐	Irregular Heartbeat	☐	☐	Knocked out / Concussion	☐	☐	Heat related problems
☐	☐	Single Testicle	☐	☐	Heart Disease	☐	☐	Recent Mononucleosi
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Liver Disease	☐	☐	Sickle Cell Trait/Anemia
☐	☐	Organ Loss (kidney, spleen, etc)	☐	☐	Tuberculosis	☐	☐	Overnight in hospital
☐	☐	Surgery	☐	☐	Prescribed EPI PEN	☐	☐	Allergies (Food, Drugs)_____
☐	☐	Medications _____						

List Dates for: Last Tetanus Shot:_____ Measles Immunization:_____Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary……☐**Yes** ☐**No**
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately……☐**Yes** ☐**No**
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school……☐**Yes** ☐**No**
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its Representative(s) ……☐**Yes** ☐ **No**

Signature (parent or legal guardian) **Date**

Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

Typing your First and Last Name in the Signature Block above, acts as your signature.

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____ Weight _____ Blood Pressure_____ Pulse_____

GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Hernia *(if Needed)*	☐	☐

COMMENTS: _____

OPTIONAL EXAMS:

VISION:

L:_____ R:_____ Corrected: _____

DENTAL:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

ORTHOPAEDIC EXAM :

	Norm	Abnl
I. Spine / Neck		
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
II. Upper Extremity		
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand / Fingers		
III. Lower Extremity		
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐

From this limited screening I see no reason why this student cannot participate in athletics.

[ ] Student is cleared
[ ] Cleared after further evaluation and treatment for:___
[ ] Not cleared for: __contact __non-contact

Printed Name of MD, DO, APRN or PA **Signature of MD, DO, APRN or PA** **Date of Medical Examination**

This physical expires 13 months from the date it was signed and dated by the MD, DO, APRN or PA.

Revised 6/18

PHSC

PRIMARY HEALTH SERVICES CENTER

Patient Packet

(Ages 0-10)

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information.

We may deny your request for an amendment, and if this occurs you will be notified of the reason for denial.

Right to Accounting of Disclosures. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as family member or friends. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we do not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request, or if we believe that it will negatively impact our ability to care for you.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

PHSC
Primary Health Services Center

If you are concerned about the care that you have received and/or the safety in the organization, please contact the Administrative Office at 2913 Betin Avenue, Monroe LA 71201. Phone: (318) 388-1250.

Right to a Paper Copy of this Notice:
You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from any of our PHSC locations identified on the front page of this notice.

Changes to this Notice:
We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with PHSC or for further information about the complaint process, please contact our Compliance Officer at (318) 388-1250. Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you gives us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

PHSC
Primary Health Services Center

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Desiard Clinic
2913 Desiard Street
Monroe, LA 71201
(318) 651-9914

Behavioral Health Clinic
2913 Desiard Street
Monroe, LA 71201
(318) 325-7740

Wellness Clinic (Women's Health and Peds)
2915 Betin Ave
Monroe, LA 71201
(318) 651-9945

Dental Clinic
2914 Betin Ave
Monroe, LA 71201
(318) 323-4450

SD Hill Clinic
850 S. 2nd Street
Monroe, LA 71202
(318) 651-0041

Grambling Family Health Center
7604 HWY 80
Grambling, LA 71245
(318) 596-1700

Mobile Health Clinic
(Serving Ouachita, Lincoln, & Morehouse Parishes)
(318) 816-2365

Effective Date: April 13, 2003

Our Pledge:

We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

For Treatment. We may use health care information about you to provide you treatment or service. For example, we may consult with a specialist who lends his/her services to the Health Center about your care or disclose to an emergency room doctor who is treating you for a broken leg, that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payments from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all of your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you may need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for our day-to-day operations, and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations.

These uses and disclosures are necessary to run the Health Center and to make sure that all of our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you.

We may also use and disclose health information:

- To remind you of a Health Center appointment
- To notify you of health related services, benefits and treatments alternatives.
- To individuals involved in your care or payment for your care.
- To organizations that handle organ and tissue donation if you are an organ donor.
- When required by federal, state, and/or local law.
- When there are risks to public health or safety.
- To workers compensation or similar programs providing benefits for work related injuries or illness.
- To military command authorities or the Department of Veteran Affairs
- To health oversight agencies that monitor the health care system, government programs and compliance with civil rights laws.
- In response to a court or administrative order.
- To coroners, health examiners, and funeral directors to the extent needed to carry out their duties.
- To business associates contracted to perform agreed upon services and billing for services.
- To authorized federal officials for intelligence, counterintelligence, protective services for the President/heads of state and other national security activities authorized by law.
- To correctional institution or law enforcement official if you are an inmate or under the custody of a law enforcement official. This release would be for the institution to provide you health care, to protect your safety and safety of others or the safety and security of the correctional institution.

Research

Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another for the same condition. All research projects however, are subject to a special approval process.

Public Health Activities. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability.
- to report births and deaths.
- to report child abuse or neglect.
- to report reactions to medications or problems with products.
- to notify people of recalls of products
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Your Rights:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them.

Right to Inspect and Copy: You have the right to inspect and obtain a copy of the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. To inspect a copy of your personal health information, you must submit your request in writing to our medical records department. If you request a copy of the information, we will charge a fee for the copying, handling, and mailing costs, and for any other cost associated with your request that are applicable with state and/or federal law. We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. We will comply with the outcome of this review.

Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

PHSC
PRIMARY HEALTH SERVICES CENTER

PATIENT'S CONSENT FORM

Name:	Date of Birth: (MM/DD/YY)	Age:	Chart Number:
Address:	City:	State:	Zip:
Email Address:	SS#:	Sex: ◯ Male ◯ Female	
Home Phone:	Mobile Phone No.:	Veteran Status: ◯ Veteran ◯ Not a Veteran	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Insurance Type:
- ☐ Medicaid
- ☐ Medicare
- ☐ Medicaid/Medicare
- ☐ Private

Race: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Also check below
☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race
☐ Race Unreported

Number in Household	Monthly Income: $
Emergency Contact Person:	Relationship:	Phone Number

CONSENT TO TREAT/PROCESS CLAIMS: I do hereby authorize PHSC or any member of their staff, under the direct supervision of appropriate licensed personnel, to provide such medical services to patients as he or she may deem reasonable and necessary to treat me, or my minor child, for any illness, condition, or disease which I am or may be afflicted.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my family physician and/or to my insurance carrier to process any and all claims. And I authorize the release of medical records from other physicians to assist in my treatment.

LABORATORY SERVICES: Please be advised that if Laboratory tests are ordered or collected that our outside laboratory will bill you for all laboratory work. If any charge went towards your insurance, it will be billed to the party (Secondary insurance/patient/patient guarantor).

ADVANCE DIRECTIVES: It is the policy of PHSC as a primary care site NOT to honor any Advance Directives a patient may possess. A minimal of basic life support efforts will be initiated by staff and EMS will be activated. The patient may invoke his/her Advance Directives after being transferred from PHSC to the nearest tertiary care site.

PATIENT RIGHTS: I, _____, have received a copy of PHSC's Notice of Privacy Practices, which makes me aware of my privacy rights and HIPAA.

CHECK ONE: ☐ **I ACCEPTED THIS COPY** ☐ **I REFUSED THIS COPY**

Housing Status:
☐ Public Housing ☐ Own a Home ☐ Family Justice/Well Springs ☐ Rent ☐ Other
☐ Homeless (If yes, please put check mark on current situation:
☐ Transitional shelter ☐ Streets ☐ Doubled-up (Living with someone else)

Typing your First and Last Name in the Signature Block below, acts as your signature.

Signature of Patient/Responsible Person X	Date:
PHSC Witness X	Date:

PHSC
PRIMARY HEALTH SERVICES CENTER

PARENTAL CONSENT FOR TREATMENT

Child's Name:	DOB:	Age:	Chart #:
Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		
Emergency Contact Person	Relationship	Phone #:	

My child (listed above) has permission to receive medical, dental and behavioral health screenings and treatment as warranted by PHSC. I authorize PHSC (and designated assistants) to administer treatment and perform necessary procedures for my child. I further authorize designated individual(s) (named below) to sign for treatments in my absence.

Name of Authorized Person designated by Parents or Guardian

Name of Authorized Person designated by Parents or Guardian

Name of Authorized Person designated by Parents or Guardian

Typing your First and Last Name in the Signature Block below, acts as your signature.

Parent/Guardian Signature | Relationship to Patient | Date

PHSC Witness | Date

*TIME TO **HIT THAT SAVE** BUTTON!*

PHSC
PRIMARY HEALTH SERVICES CENTER

Date:_____

PEDIATRIC RECORD

Patient's Name _____ ◯Male ◯Female Age _____

Parent or Guardian's Name _____

Date of Birth _____ Daytime Phone No. _____

HISTORY OF PRESENT ILLNESS

_____

_____

_____

ENVIRONMENTAL HISTORY

☐ Apartment
☐Private home
☐Bedrooms
☐Smokers
☐Pets
☐Smoke Detectors____

☐Own Room
☐Share room with
☐Persons living in house
_____
_____

Water Sewage
☐City Utilities
☐Septic tank
☐Farm water

PAST MEDICAL HISTORY:

☐No previous hospitalization ☐No major illness
☐Other: _____

BIRTH DATA

Age of Mom_____ Gravida/Para_____
Prenatal Care: ☐Yes (>8 visits) ☐No
Complications during pregnancy___
_____
☐Full term ☐Premature _____wks
Type of delivery
☐Normal Delivery
☐C-Section due to _____
Birth weight _____
Birth hospital _____
Complications after delivery _____
_____

FEEDING DATA

☐Breast feeding _____ mins.
Every _____ hrs.
☐Formula: Type _____
Amount per feeding _____
Every _____ hrs.
☐Regular Diet
☐Special Diet _____
☐Feeding problems _____
☐Good Appetite

DEVELOPMENTAL FACTS

Held up head _____
Rolled over_____
Sat alone_____
Stood alone_____
Walked_____
Said words_____
Toilet trained_____
Grade level_____

FAMILY HISTORY

Mother_____
Father_____
Brothers/Sisters:
1._____Age___Sex___Height___
2._____Age___Sex___Height___
3._____Age___Sex___Height___
4._____Age___Sex___Height___
5._____Age___Sex___Height___

Family Medical History:

☐Cancer_____
☐Heart disease_____
☐Diabetes_____
☐Anemia_____
☐Sickle Cell_____
☐Mental illness_____
☐High blood pressure_____
☐Asthma_____
☐Seizures_____
☐Bad nerves_____
☐Tuberculosis_____
☐Stroke_____
☐Others_____
_____

ABBREVIATIONS:
MGM – Maternal Grandmother
MGF – Maternal Grandfather
MA – Maternal Aunt
MU – Maternal Uncle
MGA – Maternal Great Aunt
MGU – Maternal Great Uncle
PGM – Paternal Grandmother
PGF – Paternal Grandfather
PA – Paternal Aunt
PU – Paternal Uncle
PGA – Paternal Great Aunt

RECORD OF ILLNESS

Allergies_____
Chicken pox_____
Pneumonia_____
T&A_____
Tonsillitis_____
Ear tube placement_____
Major operations and/or injuries
_____
_____

Home Meds:_____
_____

ROS:
☐Regular bowel movement
☐Good hearing
☐Good vision
☐Rashes _____
☐Other _____

ACCOUNT OF IMMUNIZATIONS

DTap	1._____	Rota	1._____
	2._____		2._____
	3._____		3._____
	4._____		4._____
	5._____	HIB	1._____
Tdap/Td	1._____		2._____
	2._____		3._____
IPV	1._____		4._____
	2._____	Va	1._____
	3._____		2._____
	4._____	HBV	1._____
PCVT	1._____		2._____
	2._____		3._____
	3._____	HAV	1._____
	4._____		2._____
MMR	1._____	MCV4	1._____
	2._____	Other	_____

Reviewed by_____ ☐ Advance Directives Policy discussed

PHSC
PRIMARY HEALTH SERVICES CENTER

Authorization to Release or Obtain Health Information

Name of Requesting Party:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security No.:
I Authorize: (indicate name of Person/Party being authorized): **PRIMARY HEALTH SERVICES CENTER**	Relationship to Patient:
Mailing Address: **2913 BETIN AVENUE**	City/State/Zip: **MONROE, LA 71201**

☒ **RELEASE** Information **TO** or ☐ **OBTAIN** Information **FROM**
(Place an "X" on the box if the information is being released OR requested.)

Name: **PRIME TIME HEAD START**	Mailing Address: **420 Wheelis St.**
Telephone Number: **(318) 855-1392**	City/State/Zip: **West Monroe, LA 71292**

Purpose of Authorization is indicated in the box(es) below. Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for disclosure to a third party. ☒ Others (Specify) **Health exams & screening**

I authorize the release of the following protected health information. *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records ☐ Laboratory Reports
☐ X-ray Reports ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

	☐ Alcoholism	☐ Drug Abuse	☐ Mental Health	☐ Vocational Rehabilitation	☐ HIV (AIDS)
	☐ Sexually Transmitted Diseases		☐ Genetics	☐ Psychotherapy Notes	
	☐ Other				

This authorization shall expire on: (Date or Event)	Signature of Individual or Personal Representative authorized by law:	Date:

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION:

We may need your authorization to use, disclose or obtain your health information for some of our services. You do not have to sign this form. If my expiration date is not entered, the authorization will expire one (1) year from the date signed.

A separate signed authorization form is required for the use and disclosure of health information for:
☒ Psychotherapy notes ☒ Employment-related determinations by an employer ☒ Research purposes unrelated to your treatment

When required by law or policy, PHSC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.
☒ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by l aw or policy, PHSC will use and disclose your health information as you have authorized on the signed authorization form.
☒ You may be required to sign an authorization before receiving research-related treatment.
☒ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. Example: In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by PHSC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to PHSC.

☒ You may cancel an authorization in writing at any time. PHSC cannot take back any uses or disclosures already made before an authorization was cancelled.
☒ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by PHSC privacy policies.

Revised 2/6/2018

*TIME TO **HIT THAT SAVE** BUTTON!*

Morehouse
Community Medical Centers, Inc
mcmcinc.org

Dear Parents,

Morehouse Community Medical Centers, Inc. (MCMC) has partnered with Primetime Head Start to provide quality health care services to your child. We would like to take this opportunity to welcome you and your child to MCMC. All students are eligible to receive the following services on our mobile clinic at Primetime Head Start:

- Wellness/Kid-med exam (includes immunizations)
- Lead Screening
- Hemoglobin Blood Count
- Dental Services

If your child has health insurance and/or Medicaid, we will bill their insurance company and/or Medicaid for payment. Any payments made by insurance and/or Medicaid will be accepted as payment in full. If your child does not have insurance and/or Medicaid, you will not receive a bill for services rendered. *No student will be expected to pay for services we provide on the mobile clinic.*

In order for your child to receive these services, please complete the enrollment forms/consents attached to this letter. Please return "completed" forms to Primetime Head Start. Students without completed forms/consents will not receive treatment from MCMC. If you would like to attend the clinic with your child, please notify Primetime Head Start.

We are looking forward to partnering with Primetime Head Start and parents to ensure your child stays healthy, in school and ready to learn.

Sincerely,

Stephenie Harris, RN
Director of Clinical Services

Mailing Address: PO Box 792, Bastrop, LA 71221
Bastrop/Main Site: 518 Durham Street, Bastrop, LA 71220 Phone (318) 283-8887 Fax (318) 281-6339
Marion Site: 3150 Taylor Street, Marion, LA 71260 Phone (318) 292-2795 Fax (318) 292-2785
Mer Rouge Site: 108 N 16th Street, Mer Rouge, LA 71261 Phone (318)239-8010 Fax (318) 647-3909
Morehouse Jr. High SBHC: 1001 West Madison Street, Bastrop, LA 71220 Phone (318) 281-8422 Fax (318) 281-2325
Bastrop High SBHC: 402 Highland Ave, Bastrop, LA 71220 Phone (318) 239-3883 Fax (318)239-3857
Riser Middle SBHC: 100 Price Drive, West Monroe, LA 71292 Phone (318) 325-0973 Fax (318)361-9323
West Monroe High SBHC: 201 Riggs Street, West Monroe, 71291 Phone (318)387-8420 Fax (318)387-7719

LOUISIANA ENROLLMENT/CONSENT FORM FOR 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	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ More than one race				
Student's Social Security Number:	School: ***Prime Time Head Start***		Student's Grade: ***Pre-K***	
Preferred Language:	Parent/Guardian 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 ☐ Amerigroup Real Solutions ☐ AmeriHealth Caritas LA
☐ LA Healthcare Connections ☐ United HealthCare Community Plan
☐ 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

HEALTH HISTORY:

Has your child ever been admitted into a hospital or had surgery? Yes ◯ No ◯ If Yes, Year: _____

Reason: _____ Hospital: _____

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

- ☐ Asthma
- ☐ Allergy
- ☐ Tonsillitis
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Skin Problems
- ☐ Been Restricted from Sports/PE for Medical Reasons
- ☐ Nervous/Mental Disorder
- ☐ Heart Disease or Murmur
- ☐ Ear or Sinus Infections
- ☐ Hearing or Speech Problems
- ☐ Vision problems
- ☐ Substance Abuse
- ☐ Endocrine (Diabetes, Thyroid, Pituitary)
- ☐ Infectious Disease -Hepatitis, HIV, TB, Meningitis
- ☐ Missing Organ (Kidneys, Eyes, Testicles)
- ☐ Blood Disorder or Birth Defects
- ☐ Genetic Disorder or Birth Defects
- ☐ Major Injuries
- ☐ Other (specify) _____

Please describe any item marked:

Office use only.

Student's Name: _____ **2nd Identifier** _____

Has your child ever had the Chickenpox? _____

FEMALES: List dates for: First Menstrual Period ***N/A*** Last Menstrual Period ***N/A***

FAMILY HISTORY:

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

☐ Asthma	☐ Nervous/Mental Disorder	☐ Endocrine (Diabetes, Thyroid, Pituitary)
☐ Allergy	☐ Heart Disease or Murmur	☐ Infectious Disease -Hepatitis, HIV, TB, Meningitis
☐ Tonsillitis	☐ Ear or Sinus Infections	☐ Missing Organ (Kidneys, Eyes, Testicles)
☐ Seizures	☐ Hearing or Speech Problems	☐ Blood Disorder or Birth Defects
☐ Kidney Disease	☐ Vision problems	☐ Genetic Disorder or Birth Defects
☐ Skin Problems	☐ Substance Abuse	☐ Major Injuries
☐ Been Restricted from Sports/PE for Medical Reasons		☐ Other (specify)_____

Please describe any item marked (Who/When):

Does your child have any known allergies to food, medications, insects, etc.? Please list.

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

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

MEDICATION CONSENT:

The School-Based Health Center will administer medications with the NP and/or Doctor's orders. Over the Counter medications may be administered such as Pain Relievers, Cold medications, Ear drops, Eye drops, Stomach medication (Pepto-Bismol, Mylanta, Midol), Wound medications, Anti-itch medication, and other topical creams/gels for other complaints, such as orajel, carmex, or vaseline. Prescription medication may be given if found necessary after examination as well. Antibiotic injections such as Rocephin may be given if deemed necessary by the NP or MD. Nebulizer medications may be administered for asthma type symptoms if necessary for treatment of students. Age appropriate Immunizations will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam.

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER EXCEPT THOSE WHICH I HAVE WRITTEN HERE:

IMMUNIZATION CONSENT:

Age appropriate Immunizations, including the Flu and HPV vaccines, will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam. I UNDERSTAND THIS STUDENT MAY RECEIVE ALL IMMUNIZATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER EXCEPT THOSE WHICH I HAVE WRITTEN HERE or checked below:

I DO NOT WANT MY CHILD TO HAVE: (please check below if you DO NOT want your child to receive either the FLU or HPV vaccine):

☐ **FLU VACCINE** (Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get flu, but the risk of getting flu is highest among children. Each year thousands of people in the United States die from flu, and many more are hospitalized. This vaccine will help prevent contraction of the flu virus.)

☐ **HPV VACCINE** (This vaccine is recommended for males and females ages 11-26 years of age. HPV is the most common sexually transmitted virus in the United States. This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.)

LAHIE Statement: We understand that the 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. We understand that the SBHC is funded through the Office of Public Health ("OPH") Adolescent School Health Program 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.

*TIME TO **HIT THAT SAVE** BUTTON!*

Office use only.

Student's Name: _____ **2nd Identifier** _____

Confidentiality: The School-Based Health Center (SBHC) adheres 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 the School-Based Health Center and the student's personal medical provider 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 the School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center. 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.

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 provided by MCMC either on-site or via mobile dental unit

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 School Based Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Morehouse Community Medical Centers.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided, including the medication consent, 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 (Ouachita Parish or Morehouse Parish Schools, as applicable) 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 Morehouse Community Medical Centers (MCMC) and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____

Signature of Parent/Legal Guardian Date

Typing your First and Last Name in the Signature Block above, acts as your signature.

_____ _____

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.

MOREHOUSE COMMUNITY MEDICAL CENTERS, INC.
PATIENT INFORMATION AUTHORIZATION FORM

NAME: _____ ADDRESS: _____

REASON FOR RELEASE:

___ Continuity of Care (PCP) ___ Patient was referred by our office __X__ Other: ***Health Exams and screenings***

INFORMATION TO BE DISCLOSED/OBTAINED: DATE FROM _____ TO _____

☐ Complete health record(s) ☐ ER Records
☐ Referral/Consults notes (dates) _____ and any subsequent visits for the same diagnosis.
☐ Most recent test results: ☐ Pap ☐ Mammogram ☐ PSA ☐ Colonoscopy ☐ Eye Exam ☐ Foot Exam
☐ Other: _____
☐ Lab Report ☐ Radiology Report
☐ Other: _____

I understand the following information will be released when included in the above unless I indicate otherwise. Do not release any ☐ AIDS or HIV test results ☐ any records of behavioral health services/psychiatric care ☐ any records of treatment for drug and/or alcohol abuse.

I **understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Morehouse Community Medical Centers, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I **understand**, unless otherwise revoked, this authorization will be in effect for the dates indicated above, or will automatically expire twelve (12) months form the date of the authorization. I **understand** that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws. I **understand** authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I **understand** Morehouse Community Medical Centers, Inc, its affiliated entities, its employees, officers, and physicians are hereby release from my legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

IDENTIFYING INFORMATION:

Patient's name at the time of treatment: _____

Date of Birth: _____ **SS #:** _____

Signature of Patient or Legal Representative: _____ **Date:** _____
Typing your First and Last Name in the Signature Block below, acts as your signature.
If signed by legal Representative, relationship:_____

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non applicable or specifically not authorized for release. This authorization is not valid if it does not contain the patient's original signature and date signed or if it has expired.

PLEASE USE THIS FORM AS THE COVER PAGE WHEN RETURNING MEDICAL RECORDS TO OUR OFFICE:

Fax records to 281-6339. Attention: _____

To be completed by entity records are requested from:
Records Submitted by (name): _____ ***Phone:*** _____

___ Records requested are attached. # of pages ___
___ Patient did not show for referral appt.
___ Patient did not have test performed at our facility.
___ Other: _____

Office use only.

Student's Name: _____ **2nd Identifier** _____

Dental Consent Form

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

1. Does your student have a dentist he/she sees routinely? ◯ No ◯ Yes Dentist's name: _____
2. When did your student last have their teeth cleaned? ☐ Not sure ☐ 6 months ago ☐ 12 months ago
3. When did your student last have dental x-rays taken? ☐ Not sure ☐ 6 months ago ☐ 12 months ago
4. How often/when does your student eat sweets, mints, or chew sugar gum? List type: _____
   ☐ Everyday ☐ once/week ☐ once/month ☐ hardly ever
5. How often/when does your student drink soda or other sweet drinks? _____
6. Is your student having any medical or dental problems, pain or discomfort at this time? If so, please describe.
   _____
7. Has your student ever experienced any complications of any kind during dental treatment? ☐ No ☐ Yes
   If yes, please explain: _____
8. Is your student allergic to latex? ☐ No ☐ Yes ☐ I don't now

I consent for my child to receive the following dental services:

- dental cleanings – Dental cleanings involve removing plaque (soft, sticky film) and tartar that has built up on the teeth over time, polishing the teeth, x-rays, and fluoride treatment.
- cavity fillings - The dentist will remove the cavity (decayed portion of the tooth) and then "fill" the area on the tooth where the cavity was removed. The filling material can be either white (composite) or silver (amalgam). Most cavity fillings require the tooth to be numbed.
- sealants - A thin protectant material that coats the chewing surfaces of the back teeth to prevent cavities.

from the School Based Health Center dental services provider. Potential complications from these procedures include, but are not limited to, sensitivity, swelling and bleeding of the gums. **Any additional dental services will have a separate consent to be signed at the time the services are provided.** The patient's medical history will be updated at every visit. If your student has a dentist that he/she sees on a regular basis, we encourage you to continue to seek care through that provider. The parent/guardian may be present for all dental visits. If you wish to be present when dental services are provided, you must contact the clinic at the numbers noted below. **I, a parent/guardian, understand that I will not be charged for any of the services provided through the health center.** I also understand the School Based Health Center or the dentist may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the School Based Health Center. I understand that the dental services billed to the student's insurance company may be counted towards any annual benefit limitations. I attest that I am the parent or legal guardian of this student and have legal authority to sign this consent form. If you have any questions, please call (318) 381-0549 or (318) 283-8887 in Bastrop or (318) 325-0973 at Riser SBHC in West Monroe.

_____ _____

Signature of Parent/Guardian Date

Typing your First and Last Name in the Signature Block above, acts as your signature.

_____ _____

Signature of School Health Staff Witness/Verify Date

EMERGENCY CONTACT 24/7: Morehouse Community Medical Centers (318)283-8887

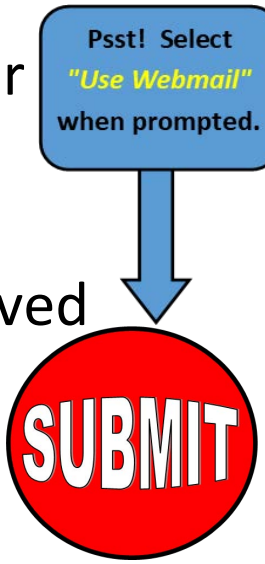
For Staff Use Only: Copy to parent as applicable – date provided/mail _____

*TIME TO **HIT THAT SAVE** BUTTON!*

Effective Date: May 8, 2017

ALL DONE! You made it!

WHAT'S NEXT?



1. **SAVE** this document ONE MORE TIME to your desktop or in your *My Documents* folder

2. Hit the **SUBMIT BUTTON or ATTACH** the saved document to an **EMAIL** sent to **enroll@primetimefamily.org** if the submit button doesn't work with your system.

3. **EMAIL** required documents for the application (on page 2) such as the birth certificate, income and residency verification, ID, physical forms, etc. to enroll@primetimefamily.org.

4. Call (318) 541-2315 for assistance or to **FOLLOW-UP**.