Go ahead and SAVE this document where you can find it and EMAIL it to enroll@primetimefamily.org!

THANKS!

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'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!*

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

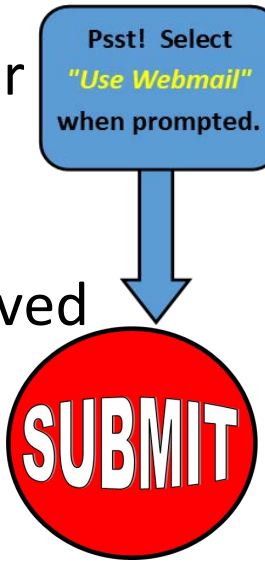
For Staff Use Only: Copy to parent as applicable – date provided/mail _____

*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**.

THE NEXT PAGES ARE FOR

OFFICE USE ONLY