Teche Health Intake/Consent Form – Glencoe Charter School

Teche Health Office Use Only: Account #: _____ Date: _____ Location: Franklin – Mobile Unit

Rev_Sep2026_KV

Please PRINT

Student's Name: _____ Date of Birth: _____

First Middle Last

Student's Mailing Address (include city): _____ Zip Code:

Student's Physical Address (if different, include city): _____ Zip Code:

SS#: | Age: | Sex at birth: ❑ M ❑ F

Gender Identity: ☐Male ☐Female ☐Transgender Male: (Female-to-Male) ☐ Choose not to disclose
☐ Transgender Female: ☐ Other:

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Other: _____
☐ Don't Know ☐ Choose not to disclose

As an FQHC, we are required to ask these questions about the student you are registering to receive services in the Mobile Unit. ☐ Unmarried ☐ Emancipated Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

Ethnicity (please check one): ☐Not Hispanic, Latino/a or Spanish ☐Hispanic ☐Latino/a or Spanish (please specify) _____ ☐ Refuse to Report

Race (mark all that apply) ☐ Caucasian/White ☐ African American/Black ☐ American Indian/Alaska Native
☐ Asian (please specify): ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____ ☐ Refuse to Report

Student's Grade:	Homeroom Teacher:

Preferred Language:	Student's Email:	Student's Cell Phone: ( )

Name of Mother (include maiden name) or Legal Guardian:	Cell Phone: ( )	Work Phone: ( )	Alternate: ( )	Employer:
Name of Father or Legal Guardian:	Cell Phone: ( )	Work Phone: ( )	Alternate: ( )	Employer:

Mother's/Guardian's Email:	Father's/Guardian's Email:

Emergency Contact Name: 18y/o or over: ☐ Yes ☐ No	Relationship to student:	Phone:
Emergency Contact Name: 18y/o or over: ☐ Yes ☐ No	Relationship to student:	Phone:

THIS INFORMATION IS REQUIRED

Student's **PCP** (**Medical Provider/Pediatrician**): _____ **( )** NO PCP Phone:

Date of your child's last comprehensive wellness visit: Month _____ Year _____

Student's **Dentist**: _____ Phone:

Date of your child's most recent dental visit: Month _____ Year _____

Preferred Pharmacy: _____

Are you interested in getting discounted prescriptions from Teche Health Pharmacy:
☐ **Yes** ☐ **No**

Names of siblings receiving Teche Health services (print):
1.
2.
3.
4.

Office Use Only:

Student Name: _____ **Date of Birth:** _____

THIS INFORMATION IS REQUIRED	✓**Check the type of health insurance your child has**:
If you are able, please send a copy of the child's insurance card	❑ Medicaid/Bayou Health Plan #: _____ (check one below) ❑ Aetna Better Health ❑ AmeriHealth Caritas ❑ Healthy Blue ❑ Humana Healthy Horizons ❑LA Healthcare Connections ❑ Private/Other Insurance Name:_____ ❑ Policy#:_____ Group#:_____ ❑ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder SSN #:_____ ❑ **No insurance** / Would you like information on health insurance? ❑ Yes ❑ No **SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY** Your household income and family size may qualify you and your family for a discount on Teche Health services. Our Patient Services Reps (PSRs) and Community Health Workers can assist you with any questions and how to apply ❒ **I WOULD LIKE TO APPLY FOR A SLIDING FEE DISCOUNT**

Collection of the following information is a requirement for Federally Qualified Healthcare Centers.

Are you living in **public housing**? (Section 8 is not considered Public Housing) ❒ Yes ❒ No

How many people live in your home, including you? _____

Head of the household: First & Last Name: _____

Relationship to child:_____ Gender: _____ DOB: _____ Phone Number: _____

Do you lack permanent housing (Are you experiencing homelessness)? ☐ No ☐ Yes, **If yes, check one: ☐ Shelter ☐ Street ☐ Transitional ☐ Doubling Up (living with friends/family)**

☐ Refuse to answer

Approximate monthly household income?

❒ Under $1,000 ❒ $1,000-$1,500 ❒ $1,500-$2,000 ❒ $2,000-$2,500 ❒ $2,500-$3,000
❒ $3,000-$3,500 ❒ $3,500-$4,000 ❒ $4,000-$4,500 ❒ $4,500-$5,000 ❒ $5,000-$5,500
❒ Over $5,500

Other Sources of Income (Mark all that apply)

❒ SSI ❒ Veteran's Assistance ❒ AFDC/TANF ❒ Food Stamps ❒ Social Security
❒ Retirement Benefits ❒ Section 8 Housing ❒ Child Support

1. Is the student a migrant? Has an immediate family member lived away from home in the last 2 years in order to work in any type of agriculture (farm work) ☐ **Yes** ☐ **No**

2. Is a parent, legal guardian, or immediate family member a **seasonal worker** (Has worked in any type of agriculture in the last 2 years, like planting, picking, preparing soil, packing house, driving a truck for any type of farm work, working with animals like cows, chickens, etc.? ☐ **Yes** ☐ **No**

3. Has an immediate family member stopped migrating to work in agriculture because of a disability or age (too old to work)? ☐ Yes ☐ No

4. Does the student have in-home WiFi? ☐ Yes ☐ No

5. Does the student or any immediate family member have a cell phone? ☐ Yes ☐ No;
☐ Android? ☐ iPhone?

6. Does the student or any immediate family member have a federally funded phone? ☐ Yes ☐ No

7. Does the student or any immediate family member have a monthly data plan? ☐ Yes ☐ No

Office Use Only:

Student Name: _____ **Date of Birth:** _____

Is your child **allergic** to any food or medicine? □ Yes □ No Or has seasonal allergies? ❒ No ❒ Yes, If yes, list:

_____

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

❒ My child takes no medications.

❒ My child takes the following medications: Add an additional page if needed

Medication Name: _____ Dose: _____ Frequency: _____

Medication Name: _____ Dose: _____ Frequency: _____

Is your child experiencing □ Anxiety, □ Depression, □ Alcohol or drug use □ Discipline problems □ Isolation

Does your child currently receive any behavioral health / counseling services? ❒ NO ❒ YES, If yes,

Name of Provider: _____ Phone #: _____

Name of agency: _____ Phone #: _____

ALL SERVICES ARE PROVIDED BY A LICENSED PROFESSIONAL.
BY SIGNING THIS CONSENT, YOU ARE AGREEING TO THE PROVISION OF THE FOLLOWING SERVICES IN THE MOBILE UNIT AT GLENCOE CHARTER SCHOOL.

- **Behavioral Health Services**
- **Individual Counseling**

Your child may receive any of the following services at the Teche Health School-Based Health Center located on the West St. Mary High School campus:

Routine healthcare	Annual wellness visits (comprehensive physical exam)
Immunizations	Health screenings like vision, hearing, blood pressure
Lab draws/diagnostic testing	Acute care for minor illness (cold/flu) and injury
Prescriptions and Medication administration	Management of chronic diseases like asthma and diabetes
Health education and prevention programs	Sports Physicals
Referral and follow-up for emergencies	Referral to specialty care (neurology, orthopedic, psychiatry)
Behavioral health/Counseling services/Telehealth	

Please call (337) 924-9646 for additional information

☐ We (student and parent/guardian) have read and understand the services to be provided by Teche Health. We both give permission for this student to receive the services provided by the program.

CERTIFICATION

☐ We understand that the Mobile Unit is operated by Teche Health and its employees and contractors

We understand that Teche Health may participate in one or more health information exchanges (HIEs), whereby the agency may share protected health information (PHI) with other healthcare providers, entities for treatment, payment, or operations.

☐ We hereby consent to the disclosure of Teche Health's records to the HIEs.

I certify that the information given on this form is true and accurate to the best of my knowledge, and I authorize Teche Health to verify this information. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and can bill me for all services received and any services paid by Teche Action Board, Inc. I also certify that I will report any changes in income or insurance status to Teche Health immediately.

Office Use Only:
Student Name: _____ Date of Birth: _____

PATIENT COMMUNICATION CONSENT

The providers and others here at Teche Health want to do all we can to protect the health information we have about your child's health and keep it private and secure. You have a right to access that information, and the right to talk to your healthcare team about it. When we need to contact you, we can only speak to you, or people you have listed below. You should list only the numbers you wish us to use to contact you.

☐ I agree to allow Teche Health to contact me in the following methods regarding my child's private health information, evaluation, and treatment.

☐ If I have checked "YES", I authorize Teche Health to leave messages for me when I am unavailable.

Home Phone _____ ☐ YES ☐ NO **Cell Phone** _____ ☐ YES ☐ NO

Work Phone _____ ☐ YES ☐NO **Other Phone** _____ ☐ YES ☐ NO

☐ I authorize Teche Health and behavioral health & medical staff to discuss my child(ren)'s healthcare information (which may include history, diagnosis, labs, test results, treatments, and other health information) with the contacts listed below. I understand that by leaving spaces blank, I am indicating my choice to be "No Information," and I do not want any information released without my expressed consent.

Name: _____ **Relationship to Patient:** _____ Contact #: _____

By my signature below I acknowledge that I have read and.understand the information provided in this form and authorize services by Teche Health as the student's general agent and accept its terms. I understand the risks associated with the **different methods of communication, and consent to the conditions, restrictions, and the patient responsibilities outlined above** as well as any other instruction that Teche Health may impose. I understand that I will be required to update this information at least **annually or when my information changes, whichever occurs first.**

It is in your best interest and in the best interest of Teche Health that Behavioral Health providers do not/will not communicate with any parents, caregivers, or patients regarding the treatment or care provided via email and/or text. Nor will we initiate communication with you as a parent, caregiver, or patient in this manner.

Confidentiality: Teche Health, operating in the Mobile Unit at Glencoe Charter School 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).

By signing below I attest that:

☐ **I consent to the exchange of relevant protected health information (PHI) between Teche Health and the student's pediatrician and/or personal medical provider(s), or specialist provider(s).**

☐ I have been given a copy of Teche Health's ***Notice of Privacy Practices and Patient's Bill of Rights and Responsibilities*** that describes how my health information is used and shared. I understand that Teche Health has the right to change this Notice at any time and that I may obtain a current copy by contacting the Teche Health, at **(337) 828-2550.**

This consent may be withdrawn or modified at any time by written notice of the parent/guardian and/or student to any of the entities referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

CONSENT SIGNATURES

✓_____

Name of Parent/Legal Guardian (Print and Signature) **Relationship to Student** **Date**

✓_____ _____

Name of Student (Print and Signature) **Date**

✓_____ _____

Name of Teche Health Witness (Signature) **Date**

TECHE HEALTH BEHAVIORAL HEALTH CHILD CLIENT QUESTIONNAIRE

PLEASE COMPLETE THE ENTIRE FORM. WE ARE HAPPY TO HELP IF YOU HAVE QUESTIONS

This form was completed by: _____ Date: _____

Child is in custody of: □ biological parents □ single biological parent □ adoptive parents □ foster parents
□ state custody □ family with no legal custody

Biological Parents' marital status: □ Married □ Never Married □ Separated □ Divorced □ Widowed

Grade: _____ Is there an IEP or 504 Plan? □ Yes □ No

Reason for visit: _____

SCHOOL PROBLEMS: Has the child ever repeated a grade? □ Yes (what grade(s) _____ □ No

Has the child ever been suspended/expelled/asked to leave school/preschool? □ No □ Yes (explain) _____

_____

Has the child had problems with attendance or tardiness? □ No □ Yes (explain) _____

Briefly describe any difficulties the child is having in school and when they started: _____

_____

Has the child ever had an educational evaluation? If so, where and when? _____

Family history of problems with learning, mental health, alcohol/drug abuse by child's parents or siblings? (explain)

_____

Please list all adults and children living in the home and their age: _____

_____

PRE-NATAL CARE: Age of mother when pregnant: _____ Did mother receive prenatal care? □ Yes □ No

Any complications during pregnancy? (explain) _____

BIRTH HISTORY: □ Child was full-term □ Premature by _____ weeks *Child's birth weight? _____

Any labor or birth complications? (explain) _____

DEVELOPMENTAL HISTORY - Give the approximate age when the child achieved the following:

First began to crawl:	Toilet trained during day:
First walked alone:	Toilet trained during night:
Began using single words:	Could feed self with no help:
Began using understandable phrases:	Could put on/take off clothes by self:

Any other concerns about the child's development? (explain) _____

MEDICAL HISTORY: (Check any that apply for current or past)

□ Surgeries □ Asthma □ Chronic ear infections
□ Glasses/Vision problems □ Hearing problems/hearing aids □ Seizures □ Orthopedic braces
□ Serious Injuries □ Head Injuries □ Food allergies □ Medication allergies _____
□ Neurological Problems □ Cerebral Palsy □ Down's Syndrome _____

Hospitalizations: _____

Prior Diagnosis: _____

List other physicians/clinics/agencies involved with the child: _____

_____

Has the child received counseling or had a psychological evaluation at a hospital or mental health center?

Name of counselor/psychologist	Clinic/facility	Date(s)	Reason for treatment/evaluation

List names of programs and people that have worked with or are currently working with the child (such as Speech, OT, PT, etc.)

Name of Program	Type of Service	Name of therapist or provider	Date(s)

Check any significant disruptions the child may have experienced within the past year:

___ Divorce/Separation of parents ___ Parent re-married ___ Moving ___ Death of pet

___ Changed Schools ___ Friend moved away ___ Illness in family (explain) _____

___ Parent lost job or financial condition changed ___ Death (explain) _____

___ Family member/child in trouble with the law (explain) _____

___ Child a victim of abuse or violence (explain) _____

Other: _____

About how many hours of sleep does the child get per weeknight? _____ hrs / weekend? _____ hrs

Specific sleeping problems? _____

Child's hobbies/interests: _____

Please list 3 things your child does well (can be related to academics, social, behavior) _____

_____

Religion/Spirituality:

A. Does the child belong to a religious community?	□ **YES** □ **NO**
B. Does the child pray or meditate?	□ **YES** □ **NO**
C. Does the child go to religious services?	□ **YES** □ **NO**

SDoH:

A. Housing Situation: □ Permanent □ Temporary □ No stable housing				
B. Living Conditions (check all that apply): □ Safe □ Unsafe □ Unclean □ Crowded □ Needs repair				
C. In your neighborhood is there: □ Violence □ Crime □ Drugs □ Unsafe Conditions				
D. Do you have running water?	□ **YES** □ **NO**		H. Do you have electricity?	□ **YES** □ **NO**
E. Do you have cooling and heating?	□ **YES** □ **NO**		I. Do you have adequate food?	□ **YES** □ **NO**
F. Can you get medical treatment if needed?	□ **YES** □ **NO**		J. Can you afford needed medication?	□ **YES** □ **NO**
G. Do you have reliable transportation?	□ **YES** □ **NO**		K. Are you able to care for dependents	□ **YES** □ **NO**
How do you usually travel? □ Personal vehicle □ Family/Friends □ Medicaid transportation □ Council on Aging □ Other _____				

Has the child demonstrated any of the following? (Explain)

☐ Persistent sadness — two or more weeks _____

☐ Withdrawing from or avoiding social interactions _____

☐ Hurting oneself or talking about hurting oneself _____

Child's Name: _____ ***DOB:*** _____

☐ Talking about death or suicide _____

☐ Outbursts or extreme irritability _____

☐ Out-of-control behavior that can be harmful _____

☐ Drastic changes in mood, behavior, or personality _____

☐ Changes in eating habits _____

☐ Loss of weight _____

☐ Difficulty sleeping _____

☐ Frequent headaches or stomachaches _____

☐ Difficulty concentrating _____

☐ Changes in academic performance _____

☐ Avoiding or missing school _____

Child's Name: _____ ***DOB:*** _____