Teche Health School-Based Health Centers Department Consent Form

SBHC Office Use Only: Account #: _____ **Date:** _____ **Location:** St. James HS SBHC

Please PRINT
Student's Name: _____
First Middle Last

Date of Birth: _____

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 enrolling in the School-Based Health Center. ☐ Unmarried ☐ Emancipated Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

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

Student's Grade: | School Attending: St. James High School

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 enrolled in the School-Based Health Center:
1.
2.
3.
4.
5.

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 ❑ United Healthcare ❑ 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** **(Complete the Lack of Income Declaration form**

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) ❒ None

❒ 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 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 LICENSED PROFESSIONALS
BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE ANY OF THE FOLLOWING SERVICES TO YOUR CHILD IF NEEDED

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

□ I, as parent/guardian, understand that while the SBHC will **not** collect any co-pays or deductibles from the students who present without a parent, a **bill** will be sent to the insurance plan(s) that are listed on the consent forms and to the parents for any co-pay or deductible that is owed, after any eligible slide discount is applied. I also understand that if I bring my student into the SBHC to be seen, staff will attempt to collect a co-pay or deductible at the time of service, after any eligible discount is applied. If I cannot pay at the time of service, I will receive a bill for the amount I am responsible for and the SBHC will also bill the insurance plan. I also understand that **Teche Health** may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to **Teche Health**.

□ I (parent/guardian) have read and understand the services to be provided at the school-based health center. **I give my permission for this student to receive the services provided by the program.**
We understand that the school-based health center is operated by **Teche Health** and its employees and contractors.
We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share protected health information (PHI) with other healthcare providers, entities for treatment, payment, or operations. **We hereby consent to the disclosure of the SBHC's records to the HIEs.**

Office Use Only:

Student Name: _____ Date of Birth: _____

CERTIFICATION

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.

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 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 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 express consent.

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

By my signature below I acknowledge that I have read and understand the information provided in this form above and authorize services by Teche Health as the patient or as the patient'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.

Louisiana Law R.S. 40:31.3 states that: Health centers in schools are prohibited from:
(1) Counseling or advocating abortion in any way or referring any student to any organization for counseling or advocating abortion.
(2) Distributing at any public school any contraceptive or abortifacient drug, device, or other 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.**

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).

By signing below I attest that:

- **I consent to the exchange of relevant protected health information (PHI) between the St. James SBHC and the student's pediatrician and/or personal medical provider(s), or specialist provider(s).**
- I have been given a copy of the organization'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 School-Based Health Center, at **(225) 258-4980.**

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 SBHC Witness (Signature) **Date**

Teche HEALTH

School-Based Health Centers Department

INITIAL HISTORY QUESTIONNAIRE

Patient Name _____ **Birth Date:** _____ **Age:** _____ ☐ **Female** ☐ **Male**

Person completing the form _____ **Date Completed:** _____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live: _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody

☐ Lives with foster family ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

Birth History Unknown

Birth Weight _____ Was the baby born at term? ☐ Yes ☐ No _____ Weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain

Was a NICU stay required? ☐ Yes ☐ No Explain

During pregnancy, did mother:

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Initial feeding ☐ Formula ☐ Breast Milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain

General

DK Do Not Know

Do you consider your child to be in good health?	☐ Yes	☐ No	☐ DK	Explain
Does your child have any serious illness or medical conditions?	☐ Yes	☐ No	☐ DK	Explain
Has your child had any surgery?	☐ Yes	☐ No	☐ DK	Explain
Has your child ever been hospitalized?	☐ Yes	☐ No	☐ DK	Explain
Is your child allergic to medicine or drugs?	☐ Yes	☐ No	☐ DK	Explain
Do you feel your family has enough to eat?	☐ Yes	☐ No	☐ DK	Explain

Biological Family History

Have any family members had the following?

Childhood Hearing Loss	☐ Yes	☐ No	☐ DK	Who	Comments	
Nasal Allergies	☐ Yes	☐ No	☐ DK	Who	Comments	
Tuberculosis	☐ Yes	☐ No	☐ DK	Who	Comments	
Heart Disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments	
High Cholesterol/Takes Cholesterol Medication	☐ Yes	☐ No	☐ DK	Who	Comments	
Anemia	☐ Yes	☐ No	☐ DK	Who	Comments	
Bleeding Disorder	☐ Yes	☐ No	☐ DK	Who	Comments	
Dental Decay	☐ Yes	☐ No	☐ DK	Who	Comments	
Cancer	☐ Yes	☐ No	☐ DK	Who	Comments	

Biological Family History *(continued from front side)*

DK = Do Not Know

Liver Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Kidney Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Obesity	☐ Yes	☐ No	☐ DK	Who		Comments	
Epilepsy or Convulsions	☐ Yes	☐ No	☐ DK	Who		Comments	
Alcohol Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Drug Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Mental Illness/Depression	☐ Yes	☐ No	☐ DK	Who		Comments	
Developmental Disability	☐ Yes	☐ No	☐ DK	Who		Comments	
Immune Problems, HIV or AIDs	☐ Yes	☐ No	☐ DK	Who		Comments	
Tobacco Use	☐ Yes	☐ No	☐ DK	Who		Comments	

Additional Family History _____

Past History

DK = Do Not Know

Does you child have, or has your child ever had:

Chickenpox	☐ Yes	☐ No	☐ DK	When	
Frequent Ear Infections	☐ Yes	☐ No	☐ DK	Explain	
Problems with Ears or Hearing	☐ Yes	☐ No	☐ DK	Explain	
Nasal Allergies	☐ Yes	☐ No	☐ DK	Explain	
Problems with Eyes or Vision	☐ Yes	☐ No	☐ DK	Explain	
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	☐ Yes	☐ No	☐ DK	Explain	
Any Heart Problem or Heart Murmur	☐ Yes	☐ No	☐ DK	Explain	
Anemia or Bleeding Problem	☐ Yes	☐ No	☐ DK	Explain	
Blood Transfusion	☐ Yes	☐ No	☐ DK	Explain	
HIV	☐ Yes	☐ No	☐ DK	Explain	
Organ Transplant	☐ Yes	☐ No	☐ DK	Explain	
Malignancy/Bone Marrow Transplant	☐ Yes	☐ No	☐ DK	Explain	
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain	
Frequent Abdominal Pain	☐ Yes	☐ No	☐ DK	Explain	
Constipation Requiring Doctor Visits	☐ Yes	☐ No	☐ DK	Explain	
Recurrent Urinary Tract Infections and Problems	☐ Yes	☐ No	☐ DK	Explain	
Congenital Cataracts/Retinoblastoma	☐ Yes	☐ No	☐ DK	Explain	
Metabolic/Genetic Disorders	☐ Yes	☐ No	☐ DK	Explain	
Cancer	☐ Yes	☐ No	☐ DK	Explain	
Kidney Disease or Urologic Malformations	☐ Yes	☐ No	☐ DK	Explain	
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain	
Sleep Problems; Snoring	☐ Yes	☐ No	☐ DK	Explain	
Chronic or Recurrent Skin Problems (e.g., acne, eczema)	☐ Yes	☐ No	☐ DK	Explain	
Frequent Headaches	☐ Yes	☐ No	☐ DK	Explain	
Convulsions or Other Neurologic Problems	☐ Yes	☐ No	☐ DK	Explain	
Obesity	☐ Yes	☐ No	☐ DK	Explain	
Diabetes	☐ Yes	☐ No	☐ DK	Explain	
Thyroid or Other Endocrine Problems	☐ Yes	☐ No	☐ DK	Explain	
High Blood Pressure	☐ Yes	☐ No	☐ DK	Explain	
History of Serious Injuries/Fractures/Concussions	☐ Yes	☐ No	☐ DK	Explain	
Use of Alcohol or Drugs	☐ Yes	☐ No	☐ DK	Explain	
Tobacco Use	☐ Yes	☐ No	☐ DK	Explain	
ADHD/Anxiety/Mood Problems/Depression	☐ Yes	☐ No	☐ DK	Explain	
Developmental Delay	☐ Yes	☐ No	☐ DK	Explain	
Dental Decay	☐ Yes	☐ No	☐ DK	Explain	
History of Family Violence	☐ Yes	☐ No	☐ DK	Explain	
Sexually Transmitted Infections	☐ Yes	☐ No	☐ DK	Explain	
Pregnancy	☐ Yes	☐ No	☐ DK	Explain	
(For girls) Problems with Periods	☐ Yes	☐ No	☐ DK	Explain	

Has had first period? ☐ Yes ☐ No Age of first period _____

Any Other Significant Problem _____

THE FOLLOWING IS A LIST OF MEDICATIONS THAT MAY BE ADMINISTERED BY THE PHYSICIAN ASSISTANT OR NURSE PRACTITIONER IN THE COURSE OF TREATING YOUR CHILD.

Medications for pain: • Ibuprofen • Naproxen • Acetaminophen • Theragesic Rub	**Medications for allergies:** • Benadryl • Loratadine
Medications used for colds & stuffy nose: • Advil Allergy/Congestion • Dayquil Severe Cold & Flu • Chloraseptic Throat Lozenges	**Medications to relieve coughing:** • Robitussin Cough Syrup • Robafen Cough Syrup • Cough Drops
Medications to cleanse wounds or eyes: • Normal Saline • Betadine Solution • Hydrogen Peroxide • Isopropyl Alcohol • Triple Antibiotic Ointment • Eye Wash Solution • Xylocaine 1% or 2% Subcutaneous	**Medications for stomach:** • Pepto Bismol • Gas-X • Emetrol • Loperamide Hydrochloride • Tums • Famotidine
Medications for Eyes/Ears/Mouth • Ear Wax Treatment Drops • Antipyrine and Benzocaine Otic Solution • Ketorolac Tromethamine Ophthalmic Solution • Artificial Tears • Oral Lidocaine • Orabase **Medications for Skin** • Triamcinolone Acetonide Cream • Clotrimazole Cream • Caladryl • Vaseline • Aloe Vera	**Other Medications:** • Azithromycin • Ceftriaxone • Depo-Medrol • Albuterol 0.083% (nebulizer) • Xopenex 0.63 mg (nebulizer) • Ammonia Inhalant • Normal Saline • Lactated Ringers • D5W Solution • Aspirin • Nitrostat • Epinephrine • Oral Glucose • Glucagon • Oxygen

****NOTE: GENERIC FORM MAY BE SUBSTITUTED**

I UNDERSTAND AND GRANT PERMISSION FOR THIS STUDENT TO RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL-BASED HEALTH CENTER **EXCEPT** THOSE WHICH I HAVE WRITTEN HERE: _____

_____

✓_____ ✓_____

Student Name (print) and DOB **Parent/Legal Guardian Name (print) & Signature and Date**

Teche Action Board, Inc. d/b/a Teche Health
1115 Weber Street, Franklin, LA 70538 | Phone: (337) 828-2550 / FAX: (337) 355-2335
Teche Health SBHC | St. James High School | Phone: (225) 258-4980
www.techehealth.org

Name: _____ Chart/Billing ID#: _____

DOB: _____ SSN#: _____

ABSENT PARENT CONSENT FOR TREATMENT FORM

I, _____, am the legal guardian for the above named patient and I **authorize the following named individuals to accompany my child in my absence to receive medical and/or behavioral treatment at Teche Health.** By signing this authorization, I am granting permission for the listed individuals to sign any legal documents such as Consents, Authorizations to Release/Request Information, etc. This authorization will be valid for one (1) year. If I must make any changes in authorized individuals, I must inform Teche Health in writing immediately.

Authorized individuals are (*Please Print*):

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ _____

Signature of Parent/Guardian/Authorized Representative Date

_____

Witness Signature

Teche Action Board, Inc.
LACK OF INCOME DECLARATION FORM

(Print) Patient Name: _____ Date of Birth: _____

This is a list of resources that are used as evidence of income to Teche Health

Please (✓) check the box(es) that affect your financial situation.

☐ I do not receive any income from employment

☐ I do not receive any unemployment compensation

☐ I do not receive food stamps

☐ I do not receive workman's compensation benefits

☐ I do not receive any disability income

☐ I do not receive any supplemental security income

☐ A family member **DOES** support me financially.

- How is this individual related to you?_____
- What is the amount this individual(s) contributes to you financially?

Amount $_____

How often? _____

I certify that the information given on this form is correct to the best of my knowledge. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and bill me for all services received and all services paid by Teche Action Board, Inc.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Teche Health Employee Date