LOUISIANA UNIFORM CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS
SCHOOL: St. James High School

Student's Name: Last First Middle Initial				ID# (Office use only.)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Race:	Ethnicity:
Student's Social Security Number:		School:		Student's Grade:
Preferred Language:	Student's 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:
Mother's Email:		Father's Email:		
Emergency Contact:		Relationship:		Phone ( )
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Student's Primary Care Physician: ______________________ **Date of your child's most recent wellness visit:** ______________				Phone ( )
Student's Dentist: ______________________ *** Date of your child's most recent dental visit:				Phone ( )
Preferred Pharmacy:	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/Bayou Health Plan #:______________(check one below) ❑ AETNA Better Health of LA ❑ AmeriHealth Caritas LA ❑ Healthy Blue ❑ LA Healthcare Connections ❑ UnitedHealthcare Community Plan ❑ Medicaid (dental) #: ______________ ❑ No insurance ❑ Private/Other Insurance Co. Name:______________ Policy holder date of birth:__________Policy holder Social Security #:__________			
If your child does not have health insurance, would you like information on no cost health insurance?❑ Yes ❑ No				
Is your child allergic to any food or medicine? ❒ No ❒ Yes If yes, list:				

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Student Name: ______________________________________ **2nd Identifier: _____________**

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

❒ My child takes no medications

My child takes the following medications:
Medication Name:___________________Dosage:________________Frequency:__________________
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Medication Name:___________________Dosage:________________Frequency:__________________
Medication Name:___________________Dosage:________________Frequency: _________________

Does your child receive any behavioral health / counseling services? ❒ Yes ❒ No
If yes, Name of behavioral health provider / counselor: ____
Office Number: ____________________________

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

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Primary and Preventive
Assessments and screening
Treatment of minor illnesses or injuries
Chronic disease management
Complete physical exams
Referrals and follow-up
Laboratory testing
Immunizations
Prescriptions
Health and Nutrition Education

Counseling Services
Assessments and screenings
Therapy/counseling
Assist with school behavioral plans
Case management
Crisis intervention

Telemedicine/Telehealth Services

LA State Law Telemedicine/Telehealth Definition

"Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables a health care practitioner and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient, or a true consultation as may be defined by rules promulgated by the board pursuant to the Administrative Procedure Act, constitutes telemedicine."

Source: *LA Revised Statutes 37:1262.*

Office Use Only
Student Name: ______________________________________ **2nd Identifier: _____________**

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 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 **St. James High School SBHC** (*insert name of the SBHC)* may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to **St. James High School SBHC** *(insert name of the SBHC).*

We (student and parent/guardian) have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

We also understand that the school-based health center is operated by **Teche Action Clinic** and its employees and contractors.

____________________________________ Relationship: ___________________________
Printed Name of Parent/Legal Guardian

____________________________________ Date: ________________________________
Signature of Parent/Legal Guardian

____________________________________ Date: ________________________________
Signature of Student

____________________________________ Position: _____________________________
Printed Name of School Health Witness/Verify

____________________________________ Date: ________________________________
Signature of School Health Witness/Verify

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.

Louisiana state law prohibits health centers in schools 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.

Effective July 2015

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