

# Healthcare Centers in Schools

A Partner of



OUR LADY OF THE LAKE  
CHILDREN'S HEALTH

## General Consent for Treatment

Student's Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_/\_\_\_/\_\_\_

I give my consent for my child, named above, to receive medical care from the school-based health program. I understand that as a participant the providers, the school nurse and your child's main health care provider may communicate by special video equipment with other physicians and health care professionals at other Healthcare Centers in Schools' (HCS) sites.

I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), healthcare student(s), and clinical staff to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science and acknowledge that no guarantees have been made to the patient named on this form.

**Medical Education\*** I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty in accordance with organizational policies.

**Photography and Other Recordings\*** I consent to photographs, audio, and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in exam room.

**Authorization for Healthcare-Related Calls, Texts and E-mails** I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and to e-mails using any e-mail address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

FMOLHS ATTN: Customer Service  
Team 5959 S. Sherwood Forest Blvd.  
Baton Rouge, LA 70816

**I agree that the services listed on page 3, unless noted in writing may be provided to my child.**

I have completed the Patient Demographic Form (see page 4) and authorize Health Care Centers in Schools to bill Medicaid or other insurance providers for these services. I assign payments of authorized benefits directly to HCCS. I understand that I will not be charged for any of the services provided through the health center that are not covered by insurance.

I understand that Health Care Centers in Schools programs may participate in one or more health information exchanges (HIEs), whereby the clinic may share my health information with other health care providers for treatment, payment, or health care operations purposes.

I also understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to School Based Health Clinic's (SBHCs) and, as part of such program; the Health Care Centers in School's Clinics are 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 health information exchanges (HIE) and consent to the disclosure of information to a HIE for such purpose. I understand that the School Based Health Clinic (SBHC) may participate in one or more HIEs, whereby the clinic 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.

*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.*

I understand that there will not be payment required for any of the services provided at the school-based health center. I also understand that Healthcare Centers in Schools or the provider will bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to HCS.

**BY SIGNING THIS CONSENT, YOU ARE AGREEING TO THE FOLLOWING SERVICES FOR YOUR CHILD:**

<b>BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW HEALTHCARE CENTERS IN SCHOOLS TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:</b>	
<ul style="list-style-type: none"> <li>• Primary and preventive health care (including immunizations)</li> <li>• Comprehensive history and physical examinations health screenings</li> <li>• Laboratory/diagnostic testing</li> <li>• Case management</li> <li>• Acute care for minor illness/injury (including medications), if indicated</li> <li>• Hearing &amp; Vision screening</li> </ul>	<ul style="list-style-type: none"> <li>• Management of chronic diseases</li> <li>• Behavioral health services</li> <li>• Referral and follow-up for emergencies</li> <li>• Referral to specialty care</li> <li>• Health education &amp; prevention programs</li> <li>• Dental services (where available)</li> <li>• Telehealth visits with a primary care, specialty, or behavioral health care provider</li> </ul>
<b>Please initial below:</b>	
<p>_____ I do hereby consent to HCS or Our Lady of the Lake Physician Group administering COVID-19 testing and notification of results.</p> <p>_____ I do consent to HCS staff administering immunizations according to the American Academy of Pediatrics immunization schedule and CDC guidance.</p>	

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL SERVICES OFFERED, EXCEPT THOSE WHICH I HAVE WRITTEN HERE:

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By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the schoolbased 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/school nurse program is operated by OLOL Children's Health care Centers in Schools and its employees/contractors and not by the local school board.

*By signing below, I acknowledge that I have read this form, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have.*

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

If the patient is a minor, the person authorized to consent should sign below.

Authorized Person for Consent Name (print): \_\_\_\_\_

Authorized Person for Consent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

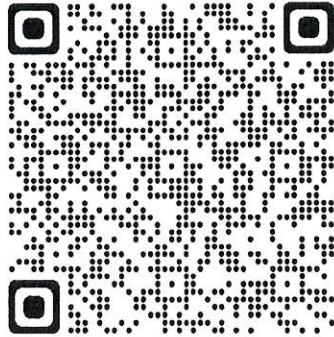
If the patient is not a minor, but is unable to consent, the person authorized to do so should sign below.

Authorized Person For Consent Name (print): \_\_\_\_\_

Authorized Person for Consent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**



I acknowledge that I have/had the opportunity to receive the Notice of Privacy Practices by scanning this code or I can request a paper copy by calling this number: 225-343-9505

Printed Patient or Patient Representative Name: \_\_\_\_\_

Relationship to Patient (if signing for the patient): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

REASON(S): \_\_\_\_\_

Employee Name and Date: \_\_\_\_\_

## LOUISIANA ENROLLMENT DEMOGRAPHIC FORM FOR HEALTH CARE CENTERS IN SCHOOLS (HCCS) SCHOOL-BASED & MOBILE HEALTH SERVICES

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: <input type="checkbox"/> M <input type="checkbox"/> F	Race:		Ethnicity:
Student's Social Security Number:				School:		Student's Grade:	
Preferred Language:			Parent/Guardian's Email:		Student's 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: ( )	
Student's Primary Care Doctor/ Provider:							Phone: ( )
Student's Dentist:							Phone: ( )
Preferred Pharmacy (Name, Street and Phone Number must be entered)							
Please check the type of health insurance your child has:		<input type="checkbox"/> Medicaid/Healthy Louisiana Plan# _____ (check one below) <input type="checkbox"/> Healthy Blue <input type="checkbox"/> AmeriHealth Caritas LA <input type="checkbox"/> Aetna Better Health of LA <input type="checkbox"/> LA Healthcare Connections <input type="checkbox"/> United Healthcare Community Plan <input type="checkbox"/> Medicaid (dental) #: _____ <input type="checkbox"/> No insurance <input type="checkbox"/> Private/Other Insurance Employer Name: _____ Please attach a copy of insurance card (front and back). Employer 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? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Is your child allergic to any food? Medicine? Insects? Latex? Other? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list:							
List of current medications student is on with dosage (how much) and how often:							

### MEDICAL AND HOSPITALIZATION INFORMATION:

Has your child been admitted into a hospital or had surgery: Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Year: \_\_\_\_\_

Reason: \_\_\_\_\_ Hospital: \_\_\_\_\_

Date of last comprehensive physical/well check \_\_\_\_/\_\_\_\_/\_\_\_\_ Performed by PCP \_\_\_\_\_ or Someone else \_\_\_\_\_

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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Endocrine (Diabetes, Thyroid, Pituitary)
<input type="checkbox"/> Allergy	<input type="checkbox"/> Depression	<input type="checkbox"/> Infectious Disease (Hepatitis, HIV, TB, Meningitis)
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Missing Organ (Kidney, Eyes, Testicles)
<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Blood Disorder or Birth Defects or Genetic Disorder
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> ADHD	<input type="checkbox"/> Been Restricted from Sports/PE for Medical Reasons
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Heart Disease or Murmur	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Ear or Sinus infections	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Major Injuries	<input type="checkbox"/> Hearing and Speech Problems	

Please describe any item marked: \_\_\_\_\_

### FAMILY HISTORY:

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart Disease/Heart Problem	
<input type="checkbox"/> Allergy	<input type="checkbox"/> ADHD	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (specify) _____	

Please describe any item marked (Who/When): \_\_\_\_\_