# CHRISTUS ST. FRANCES CABRINI HEALTH SYSTEM SBHC
# LOUISIANA ENROLLMENT/CONSENT FORM
# FOR SCHOOL-BASED HEALTH CENTERS

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|---|---|---|---|---|
| Student's Name: LAST FIRST MI | | | | ID# (Office use only.) |
| Student's Address ADDRESS AND 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: | Student's Grade: | | |
| Preferred Language: | Parent/Guardian/Student 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:<br>Please check if student does not have a Primary Care Provider ☐ | | | | Phone: |
| Name of Student's Dentist:<br>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 #:_____

Policy holder employer: _____

Does your insurance pay for prescriptions? ☐ No ☐ Yes

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

When did your child have their last physical?

Date Click or tap to enter a date. Provider

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

***Medical Authority Statement allows providers to see prescriptions your child has had in order to provide effective treatment. The health center has my permission to access this information.*** ☐ Yes ☐ No

**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.

**Confidentiality:** The School-Based Health Centers (SBHCs) adhere 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 Natchitoches Central SBHC 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 Natchitoches Central SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 318-354-1393. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices "confidential and privacy with regard to PHI (protected health information) and other private information".

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.

Student Name: Date of Birth: Click or tap to enter a date.

THE FOLLOWING LIST OF MEDICATIONS WILL BE ADMINISTERED BY THE MEDICAL STAFF AS PER DOCTOR'S ORDERS:

Medications used for pain:
Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Naproxen Sodium (Aleve)
Anbesol
Cepacol Lozenges
Midol (for menstrual cramps)

Medications used for stomachache:
Pepto Bismol
Maalox
Emetrol (for nausea relief)
Dimenhydrinate (Dramamine)
Loperamide (Immodium AD)
Famotidine (Pepcid)

Medications used for colds & stuffy nose:
Phenylephrine (a decongestant)
Guaifenesin (for mucous relief)

Medications used to relieve coughing:
Dextromethorphan (Robitussin DM)
Cough Drops

Medications used to cleanse wounds, eyes, or ears:
Betadine Solution
Triple Antibiotic Ointment (Neosporin)
Mupirocin (Bactroban ointment)
Eye Wash Solution
Hydrogen Peroxide
Isopropyl Alcohol
Bactine Spray
Normal Saline Solution

Other Medications:
Hydrocortizone Cream
Clotrimazole cream (Lotrimin)
Calamine lotion
Tecnu lotion (for poison ivy)
Vaseline
Aloe Vera
Silvadene Cream (for burns)
Lidocaine (numbing for wound care)
Silver Nitrate Sticks (mouth ulcers)
Albuterol Nebulizer Solution (for wheezing)

Medications for allergies:
Diphenhydramine (Benadryl)
Loratadine (Claritin)
Chlorpheniramine (Chlortrimeton)

Antibiotics provided by OPH (if needed by MD,NP or PA only)

| | |
|---|---|
| Zithromax | Flagyl |
| Diflucan | Rocephin (for injection) |
| Suprax | Doxycycline |

I UNDERSTAND THIS STUDENT MAY RECEIVE ALL MEDICATIONS OFFERED AT THE SCHOOL BASED HEALTH CENTER.

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

**PLEASE SUBMIT A SEPARATE SHEET LISTING ANY MEDICATIONS OR SERVICES YOU DO NOT WANT YOUR CHILD TO RECEIVE.**
**PARENT SIGNATURE AND DATE MUST BE INCLUDED.**

Student Name Date of Birth: Click or tap to enter a date.

***MEDICAL HISTORY***

**HOSPITALIZATION INFORMATION:**

Has your child ever been admitted into a hospital? ☐**YES** ☐ **NO**

**If yes**: Year Hospital: Reason:

Year Hospital: Reason:

Year Hospital: Reason:

Has your child ever had surgery? ☐**YES** ☐**NO**

List surgeries with year:

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## PATIENT HISTORY

Please mark any item(s) that applies to your child's medical history.

☐ALLERGY
☐SKIN PROBLEMS
☐ASTHMA
☐MISSING ORGAN
☐INFECTIOUS DISEASE
☐SUBSTANCE ABUSE
☐HEART MURMUR
☐ADHD/ADD

☐SEIZURE
☐CHICKENPOX
☐DIABETES
☐MAJOR INJURIES
☐VISION PROBLEMS
☐SPEECH PROBLEM
☐GENETIC DISORDER
☐TONSILLITIS
☐EAR INFECTION
☐SINUS INFECTION
☐HEARING PROBLEMS

☐BIRTH DEFECT
☐ BLOOD DISORDER
☐KIDNEY DISEASE
☐MENINGITIS
☐HEART DISEASE
☐FAINTING
☐NERVOUS/MENTAL DISORDER

Other (specify)

☐Been Restricted from Sports/PE for Medical Reasons

Please describe any item marked

FEMALES: List date for First Menstrual Period Click or tap to enter a date.

## FAMILY HISTORY

Please mark the item(s) that applies to **your family's** history (brothers, sisters, parents, grandparents)

☐ SUBSTANCE ABUSE
☐ MENTAL DISORDER
☐ ASTHMA
☐ALLERGY
☐ HIGH BLOOD PRESSURE

☐SEIZURE
☐TUBERCULOSIS
☐ CANCER
☐ GENETIC DISORDER
☐ ANEMIA

☐DIABETES
☐ STROKE
☐ SICKLE CELL
☐HEART DISEASE

OTHER (specify)

Please describe any item marked (WHO/WHEN):

**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 (where available)

**Office use only.**

**Student's Name: _____ 2nd Identifier _____**

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 Natchitoches Central SBHC or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Natchitoches Central SBHC.

**By signing below, I (parent/guardian) acknowledge that I have read and understand the services to be provided at the school-based health center. I give permission for this student to receive the services provided by the program.**

**This consent is effective while the student is enrolled in Natchitoches Central 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.**

**I give permission for my child to be photographed for the health center electronic medical records system. Yes ☐ No ☐**

We also understand that the school-based health center is operated by CHRISTUS St. Frances Cabrini Health System and its employees and contractors.

| | |
|---|---|
| Printed Name of Parent/Legal Guardian/Student | Relationship |
| Signature of Parent/Legal Guardian | Date |
| Signature of Student (optional) | Date<br>Click or tap to enter a date. |

**This consent may be withdrawn or modified at any time with written permission of the parent/guardian to the entity referred to above**. A duplicate copy of this document will be given to parents or guardians upon request.