LOUISIANA ENROLLMENT FORM FOR SCHOOL-BASED HEALTH CENTERS

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:	
Emergency Contact:			Relationship:	Phone: ( )	
Emergency Contact:			Relationship:	Phone: ( )	
Student's Primary Care Physician:				Phone: ( )	
Student's Dentist:				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/Healthy Louisiana #: _____ (check one below)

❑ Healthy Blue LA ❑ AmeriHealth Caritas LA ❑ Aetna Better Health

❑ 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 #: _____

Does your insurance pay for prescriptions? ❑ No ❑ Yes

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:

Office use only.

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

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

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.

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:

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 504/IEP
Case management
Crisis intervention
Prescriptions

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 MSA-West Academy Health Center or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to MSA-West Academy Health Center in Iberville Parish.

By signing below, 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 Access Health Louisiana 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.

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 504-568-8164.

Effective July 2017