

LOUISIANA UNIFORM CONSENT FORM FOR ELEANOR MCMAIN SECONDARY HIGH SCHOOL SBHC

Student's Name: Last		First		Middle Initial		ID# (Office use only.)
Student's Address:						Zip Code:
Student's Date of Birth:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Race:	
Student's Social Security Number:		School:			Student's Grade:	
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 & Phone Number:		Siblings enrolled in School-Based Health Center:				
Please check the type of health insurance your child has:	<input type="checkbox"/> Medicaid/LaCHIP #:		_____		<input type="checkbox"/> No	
	<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Does your child have any health problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list:						
Is your child allergic to any food or medicine? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list:						
List of medications student is currently taking:						
List any overnight hospitalizations or surgeries:						
Describe any major injuries:						
THE SCHOOL HEALTH CENTER SERVICES WILL BE PROVIDED ONLY WITH THIS CONSENT SIGNED BY THE PARENT/LEGAL GUARDIAN.						
School-Based Health Centers offer the following services:						
◆ Primary and preventive health care ◆ comprehensive history and physical examinations ◆ immunizations						
◆ health screenings ◆ laboratory/diagnostic testing ◆ acute care for minor illness and injury						
◆ management of chronic diseases ◆ behavioral health services ◆ health education and prevention programs						
◆ case management ◆ referral and follow-up for emergencies ◆ referral to specialty care						

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 through the health center. I also understand that the physician/nurse practitioner may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the billing agent.

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

We also understand that the school health center is operated by LSUHSC Department of Pediatrics and its employees and contractors. LSUHSC sponsors the Health Center in cooperation with the OPH Adolescent Health Initiative.

The New Orleans Public School Board provides physical space, utilities, Internet access and security for the Health Center. The Health Center staff works with the school faculty/staff to provide health education programs.

Printed Name of Parent/Legal Guardian

Relationship: _____

Signature of Parent/Legal Guardian

Date: _____

Signature of Student

Date: _____

Printed Name of School Health Witness/Verify

Position: _____

Signature of School Health Witness/Verify

Date: _____

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 1-800-219-4419.