LEGACY COMMUNITY HEALTH

Date: _____ Chart #_____

School Based Health Care

(281) 628 2050

School Name: _____ **Grade:** _____ **Current student:** ☐ **Sibling of current student:** ☐

STUDENT INFORMTION

Student Name :	Date of Birth:
Street:	Apt number:
City:	Zip code:
Gender: Male: ☐ Female: ☐	Is the student homeless? Yes: ☐ No: ☐
Race: White: ☐ Black/African American: ☐ American Indian/Alaskan Native: ☐ Asian: ☐ Pacific Islander: ☐ Other: ☐ I do not wish to report: ☐	
Ethnicity: Hispanic: ☐ Non-Hispanic : ☐	
Is the student a patient of Legacy Community Health? Yes: ☐ No: ☐	

PARENT INFORMAITON

1.Parent/Guardian Name:	Phone:	Phone – Alternate:	Relationship to student:
2.Parent/Guardian Name:	Phone:	Phone – Alternate:	Relationship to student:
Emergency Contact Name:	Phone:	Phone- Alternate:	Relationship to Student:
Parent/ Guardian email:			

INSURANCE

Does the student have insurance? Yes: ☐ No: ☐	Type of insurance: Medicaid: ☐ CHIP: ☐ Private: ☐	
If student is uninsured, you may contact the clinic staff to connect you with our eligibility department to receive assistance insurance enrollment or qualify for sliding scale fees.	Name of insurance plan:	
	Insurance ID #:	PO Box Address:

Student name: _____ **Date of Birth:** _____ **School:** _____

CONSENT FOR MEDICAL SERVICES

-I am the custodial parent or legal guardian of the minor child named. I understand that it is not required to attend my child's pediatric appointment, but I may if I choose. I authorize the nurse practitioner or doctor to treat my child in my absence and if necessary, an authorized adult may accompany my child to receive services. The authorized adult may be a medical assistant, school nurse, principal, administrative employee, or an adult named by one of them.

-I understand that I must be present for the initial appointment for Therapy services and each appointment for Psychiatry services

-I authorize and consent to this child receiving the following services from Legacy Community Health, and its affiliated providers under the terms provided below. Services may include, but are not limited to:

- Mandated school health services including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
- Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
- Medically prescribed laboratory tests such as for anemia, sickle cell and diabetes.
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
- Behavioral health services including counseling, therapy, evaluation, diagnosis, treatment and referrals.
- Reproductive health care services, including contraception, testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate per the Texas Family Code.
- Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.

*See attached information regarding reproductive health services and parental consent.

Consent for: Pediatric Services: ☐ **Behavioral Health Services:** ☐

Parent/Guardian Signature: _____ **Date:**_____

· I have read and understand the services listed above and consent for my child to receive medical care, treatments, and on-site diagnostic tests that Legacy Community Health Services believe are necessary for my child

DISCLOSURES, RELEASES & AUTHORIZATIONS

-I authorize the school nurse/school representatives, the local public health department(s), dentist, and/or medical provider to obtain my child's complete medical records which may include vaccine records, dental records, laboratory testing, radiograph results, HIV status, and behavioral health and substance abuse issues.

-A clinical summary is provided following most visits. This clinical summary will contain my child's personal health information which includes, but is not limited to: the patient's name, date of birth, medical diagnoses, medications and health education. This summary may be in the format of a letter placed in my child's backpack or delivered through the mail and/or through a phone call.

-I authorize and direct Legacy Community Health Services to bill on my behalf or my child's behalf and collect payment from any insurance or third party payer that covers the services provided to my child. If further treatment is advised by our professional health care providers, a referral will be made to me to the address and/or phone number of record on this application form.

· I agree to the terms and information above. I am giving this consent of my own free will. I fully release KIPP Public School/YES Prep School and Legacy Community Health as well as their Officers, Directors, Board Members, employees, and agents (ie.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses of any kind or nature whatsoever resulting from, relating to or arising out of my child's receipt of services.

-I understand I may receive a bill for my co-payment or co-insurance.

-I acknowledge receiving notice of privacy practices today before signing.

-I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Parent/Guardian Signature:_____ **Date:**_____