NAME:_____

SCHOOL:_____

TEACHER:_____

CONSENT FORM

Patient's Name:_____ Date of Birth:_____ Sex: ☐ M ☐ F

Parent/Guardian Name:_____ Parent/Guardian D.O.B._____

Parent/Guardian Email Address:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____

Emergency Contact Name:_____ Emergency Phone:_____

Race: ☐ Asian ☐ Black ☐ Native American ☐ White ☐ Other:_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Preferred Language

REQUIRED INSURANCE INFORMATION

☐ MEDICAID: Medicaid ID Number:_____

MCO: ☐ Amerigroup ☐ CareSource ☐ Peach State ☐ WellCare

☐ COMMERCIAL INSURANCE:

Insurance Company:_____ ☐ PPO ☐ HMO

Subscriber Name:_____ DOB:_____

Subscriber ID Number:_____

☐ UNINSURED: # people in your household_____ Total Monthly Income:_____

Pharmacy Name:_____ Pharmacy Location:_____

All children with parental consent will be served, regardless of their insurance coverage, or their ability to pay. Insurance information is being collected to assist with the reimbursement for services where applicable. I understand that my consent allows the health provider and professional staff of the school-based health center to provide the comprehensive health services listed below and that confidentiality is ensured. No medical experimentation or research will be done on my child without my written consent. I understand that I have the right to withdraw (or add services) to this consent upon notice to the Health Center staff:

Urgent/First Aid • Routine School and Sports Physicals • Immunizations • Medically Prescribed Lab Test · Examination diagnosis and treatment of complaints of pain or illness being identified by my child · Ongoing care of existing medical conditions • Health Education • Professional counseling in regard to *nutrition, personal hygiene, mental health, sexuality and substance abuse • Behavioral and Developmental Assessment and Treatment*

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at **404-564-7749**. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

Signature (Parent/Guardian):_____ Date:_____

NAME:_____

SCHOOL:_____

TEACHER:_____

STUDENT HEALTH HISTORY

In order to provide the best health care for your child, we must understand your child's health history.

Student Name:_____ Date of Birth:_____ Grade:_____ Sex: ☐ M ☐ F

Has your child ever had any of the following conditions? *(check all that apply)*

☐ High Blood Pressure	☐ Heart Condition	☐ Asthma
☐ Diabetes	☐ Serious Skin Condition	☐ Rheumatic Heart Fever
☐ Severe Allergies	☐ Dizziness and Fainting	☐ Frequent and Severe Headaches
☐ Scoliosis	☐ Bone or Joint Problems	☐ Excessive Worry
☐ Ulcer	☐ Chronic Abdominal Pain	☐ Excessive Colds
☐ Speech Problems	☐ Eye Trouble	☐ Wear Glasses
☐ Frequent Ear Infections	☐ Hearing Loss	☐ Intestinal Trouble
☐ Epilepsy (Convulsions)	☐ ADD/ADHD	☐ Depression
☐ Severe Head Injury	☐ Other:_____	☐ Other:_____

Please provide details, and list any medical problems, injuries or behavioral health issues that haven't been mentioned above._____

_____

_____

ALLERGIES:_____

SURGERIES:_____

MEDICATIONS:_____

Will you provide medications to the school nurse for administration? ☐ YES ☐ NO

Has your child had an annual physical/checkup within the last 12 months? ☐ YES ☐ NO

TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE

Was the child born outside the U.S.? ☐ YES ☐ NO (If yes, where?_____)

Has the child traveled outside the U.S.? ☐ YES ☐ NO (If yes, where?_____)

Has the child been exposed to anyone with TB infection? ☐ YES ☐ NO

Does the child have close contact with a person who has a positive TB skin test? ☐ YES ☐ NO

Signature:_____ Date:_____

Printed Name:_____ Relationship to minor:_____

Thank you for providing this information so that we may better care for your child.

NAME:_____

SCHOOL:_____

TEACHER:_____

TREATMENT CONSENT

☐ I (we) hereby voluntarily consent to such diagnostic and therapeutic procedures as may be ordered or deemed advisable by my attending Provider or his/her designee.

ASSIGNMENT OF INSURANCE BENEFIT

☐ The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/ or dependents. I further expressly agree and acknowledge that my signature on this document authorizes HEALing Community Health, to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I hereby assign all medical and surgical benefits, which I am entitled to directly to HEALing Community Health. I understand may be financially responsible for all charges incurred that my insurance company does not cover.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY

☐ I have received the HEALing Community Health Notice of Privacy Practices. The personal Representative is the patient's decision maker if the parent cannot act for themselves. It can be the parent, legal guardian, health care surrogate or other person.

ACKNOWLEDGEMENT OF GEORGIA IMMUNIZATION REGISTRY

☐ I understand that Georgia Immunization Registry (GRITS) in an immunization registry that makes retrieving my immunizations records easier for me and my doctor. It is only accessible by authorized health care providers.

ACKNOWLEDGEMENT OF MEDICATION HISTORY PROFILE

☐ I give permission for HEALing Community Health to obtain my medication history from my pharmacy, health insurance and other health providers. This will make retrieving my medication history easier. The information will become part of my electronic medical record that is only accessible by authorized health care providers.

ACKNOWLEDGEMENT OF PATIENT HEALTH PORTAL

☐ I give permission for the HEALing Community Health Patient Portal to be used as a form of communication between myself, my health provider and health care organization. Communications will be through a secure and efficient web-based portal.

Signature:_____ Date:_____

Printed Name:_____ Relationship to Minor:_____