DEPAUL COMMUNITY HEALTH CENTERS

School-Based Dental Health Services Consent Form

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: ( )
Student's Primary Care Physician:				Phone: ( )
Student's Dentist:				Phone: ( )
Preferred Pharmacy (Name, Street and Phone Number)		Names of siblings enrolled in School-Based Health Center:		

Please check the type of health insurance your child has:

☐ Healthy Louisiana Plan #:_____(check one below)
- ☐ Amerigroup Real Solutions LA
- ☐ AmeriHealth Caritas LA
- ☐ Aetna
- ☐ LA Healthcare Connections
- ☐ United Healthcare Community Plan LA

☐ Medicaid #:_____

☐ No Insurance

☐ **Other Insurance** **Employer Name**:_____

Please send a copy of insurance card (front and back) to DCHC

Employer 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:

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

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW DCHC TO PROVIDE ONLY DENTAL SERVICES TO YOUR CHILD.

Please complete back.

HOSPITALIZATION INFORMATION:

Has your child been admitted into a hospital or had surgery: Yes_____ No_____ If yes, Year: _____

Reason:_____ Hospital_____

Please mark the item(s) that apply to your child's medical history:

____Asthma	____Behavior Problems	____Endocrine (Diabetes, Thyroid, Pituitary)
____Allergy	____Depression	____Infectious Disease (Hepatitis, HIV, TB, Meningitis)
____Tonsillitis	____Substance Abuse	____Missing Organ (Kidney, Eyes, Testicles)
____Seizures	____Anxiety	____Blood Disorder or Birth Defects or Genetic Disorder
____Kidney Disease	____ADHD	____Been Restricted from Sports/FE for Medical Reasons
____Skin Problems	____Heart Disease or Murmur	____Vision Problems
____Chicken Pox	____Ear or Sinus infections	____Other (specify)_____
____Major Injuries	____Hearing and Speech Problems	

Please describe any item marked: _____

FAMILY HISTORY: Please mark the item(s) that apply to your family's history: (B=brothers, S= sisters, P=parents and G=grandparents)

____Cancer	____Depression	____Genetic Disorder	____Tuberculosis
____Asthma	____Substance Abuse	____Sickle Cell	____Stroke
____Seizures	____Anxiety	____Heart Disease/Heart Problem	
____Allergy	____ADHD	____High Blood Pressure	
____Anemia	____Diabetes	____Other (specify)	

Please describe any item marked (Who/When):_____

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 DePaul Community Health Centers (DCHC) or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to DCHC.

I also understand that the school based health services are operated by DCHC and its employees and contractors and not with my child's school.

Confidentiality: 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 DCHC has the right to change this notice at any time. I may obtain a current copy by contacting the Administrative Office.

DCHC Statement: I understand that the DCHC 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. I hereby consent to the disclosure of the DCHC's records into the HIEs.

Printed Name of Parent/Legal Guardian	**Relationship (to student)**
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.