# FMC School-Based Clinic Enrollment Form

## DEMOGRAPHIC INFORMATION

Last Name: First Name: Middle Initial: ID#:

Student's Address: Zip Code:

Student's Date of Birth: Age: Sex: ☐ Male ☐ Female Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other:

Student's Social Security Number: School: Student's Grade:

Preferred Language: Parent or Guardian: Contact Number:

Name of Mother/Legal Guardian: Home Phone: Cell Phone: Employer:

Name of Father/Legal Guardian: Home Phone: Cell Phone: Employer:

Emergency Contact: Relationship: Contact Number:

Emergency Contact: Relationship: Contact Number:

Primary Care Physician: Dentist: Pharmacy:

## HEALTH INSURANCE INFORMATION

Name of Policy Holder: Medicaid (Plan Name): Plan Number:

Policy Holder Date of Birth: Private Insurance (Plan Name): Plan Number:

Policy Holder Social Security Number: If your child does not have health insurance, would you like information regarding financial assistance? ☐ YES ☐ NO

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

Does your child have any known allergies? If so, please list them below:

| YES | NO | Medical Condition | YES | NO | Medical Condition | School Location |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Physical Disability | ☐ Baskin School |
| ☐ | ☐ | ADHD/ADD | ☐ | ☐ | Lung Problems | ☐ Crowville School |
| ☐ | ☐ | Allergies | ☐ | ☐ | Scarlet Fever | ☐ Family Community Christian School |
| ☐ | ☐ | Asthma (Please bring inhaler) | ☐ | ☐ | Seizures | ☐ Fort Necessity School |
| ☐ | ☐ | Birth defect | ☐ | ☐ | Sickle Cell Disease | ☐ Franklin Academy |
| ☐ | ☐ | Brain/head Injury | ☐ | ☐ | Vision/Eye Disorders | ☐ Franklin Parish High School |
| ☐ | ☐ | Broken Bone | ☐ | ☐ | Staph Infections | ☐ Gilbert School |
| ☐ | ☐ | Heart Problems | ☐ | ☐ | **Surgery History:** | ☐ Horace G. White Learning Center |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Tubes in Ears | ☐ Winnsboro Elementary School |
| ☐ | ☐ | Dental Disease | ☐ | ☐ | Appendectomy | |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Tonsillectomy | |
| ☐ | ☐ | Eating Problems/Poor Appetite | ☐ | ☐ | Adenoidectomy | |
| ☐ | ☐ | Ear Infections | ☐ | ☐ | Bone or Joint Surgery | |
| ☐ | ☐ | Hearing Loss | ☐ | ☐ | **Has your child ever been admitted to the hosptial?** | |
| ☐ | ☐ | Speech Problems | **Reason for Admission:** | | | |
| ☐ | ☐ | Mental Health Concerns | | | | |
| ☐ | ☐ | Depression | | | | |
| ☐ | ☐ | Suicidal thoughts | | | | |
| ☐ | ☐ | Eating Disorders | | | | |
| ☐ | ☐ | Physical Disability | | | | |

# FMC School-Based Health Centers

## PROTECTED HEALTH INFORMATION CONSENT FORM

The School-Based Health Centers are a joint effort of Franklin Medical Center and the Franklin Parish School District.

**WHAT IS A SCHOOL-BASED HEALTH CENTER?** A comprehensive, primary health care center located in a school. Staff includes: medical providers such as nurse practitioners.

**HOW CAN A STUDENT USE THE HEALTH CENTER?** A student must have a consent form signed by his/her parent or guardian in order to receive health center services. If the student is 18 years old or older or emancipated, he/she can sign his/her own Consent for Services form. Each year the School-Based Health Centers will send home the Consent for Services form in order for your child to remain an active member of the School-Based Health Centers.

Your health and health care information are both personal and private. Franklin Medical Center is dedicated to protecting your health care information. This HIPAA Consent Form provides information about how Franklin Medical Center may use and disclose your Protected Health Information (PHI).

As part of your medical treatment, Franklin Medical Center originates and maintains paper and/or electronic records which contain PHI such as: demographic information, personal and family histories, symptoms, examination, test results, diagnoses, past, present and future plans for care and treatment, and information received from other health care providers, your employer and any health care plan. Franklin Medical Center maintains Privacy Practices and Policies regarding the disclosure of PHI.

Please initial each line below acknowledging understanding of the HIPAA/Patient Rights:

_____ -Protected Healthcare Information may be disclosed or used for treatment, billing and payment.

_____ -The parent or guardian has the right to review FMC Privacy Policies and Practices

_____ -The parent or guardian may revoke their consent in writing at any time

_____ -The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Franklin Medical Center reserves the right to change its Privacy Practices and Policies at any time. A revised copy of the Privacy Practices and Policies may be requested by contacting the office.

Legal Name of Parent/Guardian

Relationship to Student

Name of Student

Date

**School Location:**

- ☐ Baskin School
- ☐ Crowville School
- ☐ Family Community Christian School
- ☐ Fort Necessity School
- ☐ Franklin Academy
- ☐ Franklin Parish High School
- ☐ Gilbert School
- ☐ Horace G. White Learning Center
- ☐ Winnsboro Elementary School

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# FMC School-Based Health Centers

## PATIENT CONSENT FORM

BY SIGNING THIS CONSENT,YOU ARE AGREEING TO ALLOW THE FRANKLIN MEDICAL CENTER SCHOOL-BASED CLINIC (FMC SBC) TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

Comprehensive history and physical evaluation  Health screenings  Care of minor illness and injury including medications

Health education and prevention programs  Referral and follow-ups for emergencies or specialty care

I, as guardian, understand that I will not be charged for any services provided at the school-based clinic and will be held responsible for any co-pays or deductibles. I understand that the FMC SBC may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to the FMC school-based clinic.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the FMC SBC. We both give permission for this student to receive the services provided by this program.

This consent is effective while the student is enrolled in the Franklin Parish School System unless the FMC SBC is notified in writing, that I no longer wish for my child to receive these services. I understand that I may be asked to complete a one page form yearly to update important information.

We acknowledge that we understand the FMC SBC is operated by Franklin Medical Center, and it's employees.

Health Exchanges: We understand that the FMC SBC may participate in one or more health information exchanges (HIEs), whereby the SBC may share my health information with other health care providers for treatment. We consent to the disclosure of the SBC's health records into the HIE's.

Louisiana Law R.S. 40:31.3 states that school-based health centers are prohibited from: (1) counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion. (2) Distributing contraceptives or abortifacient drug device or similar products.

Legal Name of Parent/Guardian

Relationship to Student

Name of Student

Date

This consent may be withdrawn or modified at any time with written consent of the parent/guardian. A duplicate of this form will be given to the parent/guardian upon request.

**School Location:**

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- ☐ Crowville School
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# FMC School-Based Health Centers

## Medication Consent Form

Medications listed below will be administered by the nurse as needed per physician/nurse practitioners order:

### Brand or generic may be used for the following complaints:

**Anti-infective (topical):** Bacitracin or Neosporin

**Anti-itch (topical):** Benadryl Cream or Ointment**,**

**Eye:** Visine, Eyewash Solution

**Gastrointestinal:** Antacids, Mylanta

**Mouth:** Oragel

**Pain:** Ibuprofen, Acetaminophen

**Respiratory:** Antihisamines, Throatdrops/lozenges, Cough Suppressants, Chest Decongestants

**Low Glucose:** Dextrose tablets or sugar candy

**Please list medications, if any that you DO NOT want your child to receive:**

Legal Name of Parent/Guardian

Relationship to Student

Name of Student

Date

This consent may be withdrawn or modified at any time with written consent of the parent/guardian. A duplicate of this form will be given to the parent/ guardian upon request.

**School Location:**

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