Chalmette High School

School Based
Health Center

RETURNING STUDENT PACKET

July 1, 2023

Dear Parent or Guardian:

We are excited about the 2023-2024 school year and welcome back our returning students.

Please **complete the enclosed form** in this packet and return it to the Health Center in the envelope provided. We also have the ability, should the need arise, to provide telehealth visits. Please complete the Telehealth Consent to allow these services to be available to your child.

If your child has health insurance, please enclose a copy of the health insurance card.

For information on School Based Health Center services, please visit our website by scanning the QR Code below. If you have any questions or need any additional information about health services available to your child at school, please do not hesitate to contact us at 504-333-6988.

Thank you in advance and we look forward to serving your healthcare needs.

The School Based Health Center Staff

Este paquete está disponib le en español en el Centro de Salud Escolar a solicitud.

CHALMETTE HIGH SCHOOL, SCHOOL BASED HEALTH CENTER
2023-24 Enrollment/Consent Annual Update

Welcome back to Chalmette High School for the 2022-23 school year! Please complete and return this form to update your child's medical records and renew your permission for them to continue receiving services at Chalmette High School, School Based Health Center. **Please complete in Blue or Black ink.**

Name of Student: ______________________ DOB: ________ Age: ____ Grade: ____

Address: ______________________ City/State/Zip: ______________________

Student Phone #: ______________________

Legal Guardian Name: ______________________

Phone #: (c) ____________ (w) ____________ Email: ______________________

Legal Guardian Name: ______________________

Phone #: (c) ____________ (w) ____________ Email: ______________________

Emergency Contact Name: ______________________ Phone #: ____________

Primary Care Provider: ______________________

Does your child have **insurance coverage**? YES NO

If yes, please list the insurance: ______________________, and policy # ____________

Is your child taking any daily **medications**? YES NO

If yes, name of medication and dose: ______________________

Does your child have any known **allergies**? YES NO

Please list: ______________________

Has your child been treated in an **emergency room** or medical office for a serious illness or injury during the summer break? YES NO

List changes in family medical history in the past year: ______________________

Any medical/mental health concerns: ______________________

☐ I would like to receive emails/text messages about appointments and Health Center events.

We (student and legal guardian) have read and understand the services to be provided at the School Based Health Center. This student may continue to receive the services provided by the Chalmette High School, School Based Health Center. The original Enrollment/Consent form is unaffected and shall continue in effect in accordance with its terms.

______________________ Printed Name of Legal Guardian	______________________ Relationship
______________________ Signature of Legal Guardian	______________________ Date
______________________ Signature of Student	______________________ Date

This consent may be withdrawn or modified at any time with written request of the legal guardian and student to the entity referred to above.

Office Use Only

ID#: ______________________ School Year ______________________

Reviewed By: ______________________ Follow-up Plan (if needed): ______________________

Effective Date: July 1, 2023

Chalmette High School, SBHC (504) 333-6988 ▪ Nunez Health Center (504) 278-6318 ▪ Rowley Alternative School Mental Health (504) 278-6318

TELEHEALTH CONSENT

Consent for Treatment:_______________________________________ (Patient First and Last Name)

I consent to telehealth/telemedicine care performed by the health care providers at Methodist Health System Foundation (MHSF) Health Centers. This includes examinations, diagnostic testing, treatment and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth/telemedicine at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus. Telemedicine involves transmission of video, photo. graphs, and/or details of my medical record such as x-rays and test results (collectively "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth/telemedicine encounter and have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telehealth/telemedicine services at any time and request alternative services such as an in-person appointment. However, I understand that the equivalent in-person services might not be available at the same location as the telehealth/telemedicine services.
- If I do not want to receive health care services by telehealth/telemedicine, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled.
- If an emergency occurs during a telehealth/telemedicine encounter, 911 will be called and the Provider will stay on the video/telephone until help arrives.
- Records and Release of Information-Transmitted Data may become part of my medical record. Data will not be transmitted to people outside of my health care team except if I provide additional consent.
- I will have access to all of the information in my medical record resulting from the telehealth/telemedicine services that I would have for a similar in-person visit, as provided by federal and state law.
- The Provider may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.
- All releases of information are subject to the same laws and regulations as in-person care.

Payment Agreement/ Assignment of Benefits:

I authorize the Providers and MHSF to file claims for payment of any portion of the patient's bills and assign all rights and benefits payable for healthcare services to the provider or organization providing the services.

Consent to be Contacted (Telephone Consumer Protection Act):

By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, MHSF and/or other providers involved with the provision of telehealth/telemedicine services to service my account(s) (including contacting me about appointment reminders, surveys, and my care), the Providers, MHSF and/or other providers involved with the provision of telehealth/telemedicine services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable.

By signing this document, you agree to the above consent for treatment and services through Telehealth/Telemedicine (electronically signed or by pen).

Signed by: ____ Relationship: ____________________

Patient or Guardian of Minor (Patient younger than 18 years of age)

Print: ____ Date: __________________________

Signature of Minor Patient : ________________________________

(Optional)

Rev: July 2022