MHSF HEALTH CENTERS
(CHALMETTE HIGH SCHOOL AND C.F. ROWLEY ALTERNATIVE SCHOOL)
2023-24 LOUISIANA ENROLLMENT/CONSENT FORM
FOR SCHOOL BASED HEALTH CENTERS

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	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	
Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race ❑Other				
Student's Social Security Number:	School:			Student's Grade:
Preferred Language:	Legal Guardian Email:			Student's Cell Phone:
Name of Legal Guardian 1 (include maiden name):	Cell Phone:	Alternate Phone:	Employer:	
Name of Legal Guardian 2:	Cell Phone:	Alternate Phone:	Employer:	
Emergency Contact:		Relationship:		Phone:
Emergency Contact:		Relationship:		Phone:
Do you have a Primary Care Provider: ❑ Yes ❑ No If yes, Name:_____				Phone:
Preferred Pharmacy:				

Please check the type of health insurance your child has:

❑ No insurance

❑ Medicaid: _____

❑ Private/Other Insurance Co.
(**Please attach a copy of the front and back of insurance card or complete information below.)**
Name: _____
Company 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? ❒ Yes ❒ No

Would you like information on no cost health insurance? ❑ Yes ❑ No

Office Use Only

Student's Name: _____ ID Number: _____

Health Information Exchange Statement: We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the SBHC may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the SBHC is funded through the Office of Public Health ("OPH") Adolescent School Health Program and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of School Based Health Centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Confidentiality: The School Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). We acknowledge receipt of Methodist Health System Foundation, Inc.'s Notice of Privacy Practices, and consent to the use and disclosure of medical information in the ways described in it.
Services provided via telehealth/telephone (if utilized) are done in a HIPAA secure manner.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited 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**.**

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD (where available):

♦primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations (with prior verbal or written consent) ♦medical and/or mental health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available)

Office Use Only

Student's Name: _____ ID Number: _____

I, as legal guardian, understand that I will not be charged for any of the services provided at the School Based Health Center. I also understand that Methodist Health System Foundation, Inc. or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Methodist Health System Foundation, Inc.

We (student and legal guardian) acknowledge that we have read and understand the services to be provided at the School Based Health Center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in a St. Bernard Parish Public School unless the School Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

This consent will be honored for medical and mental health services at all MHSF Health Centers (Chalmette High School, C. F. Rowley Alternative School or Nunez Community College including dual enrollment) unless otherwise requested by the patient and/or legal guardian.

We also understand that the School Based Health Center is operated by Methodist Health System Foundation, Inc. and its employees and contractors, in facilities furnished by St. Bernard Parish Schools.

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

_____ _____
Printed Name of Legal Guardian/Student Relationship

_____ _____
Electronic or Written Signature of Legal Guardian Date

_____ _____
Electronic or Written Signature of Student (optional) Date

This consent may be withdrawn or modified at any time with written permission of the legal guardian and student to the entity referred to above. A duplicate copy of this document will be given to legal guardians upon request.

Effective Date: July 1, 2023

[Fillable PDF Document]