SCHOOL BASED HEALTH CENTER CONSENT FORM

LifeLong Medical Care
Health Services For All Ages
a california health center

Elmhurst United
1800 98th Avenue, Suite 103
(*Corner of Birch St. & 98th Ave.*)
510-639-1479 FAX 510-639-3289

Emery Secondary/Anna Yates
4727 San Pablo Ave. B214
Emeryville, CA 94608
510-833-7050 FAX 510-553-2214

West Oakland Middle School/ MLK Jr Elementary
991 14th Street, Bldg. H
Oakland, CA 94607
510-874-7272 FAX 510-834-3586

First Name: ________________ Last Name: ________________ Chosen Name: ________________

School: ________________ Grade: ________ Birthdate: ____________ Sex: ❑ Male ❑ Female ❑ Transgender

Primary language spoken at home: ____________ Student's Social Security Number: ________-________-________ ❑ No Social Security Number

Race: ❑African American/Black ❑American Indian/Native American ❑Alaska Native ❑Asian ❑Caucasian/White ❑Native Hawaiian ❑ Pacific Islander ❑ Latino/Hispanic ❑More than one Race ❑Other(specify: ________________

Ethnicity: ❑Latino/Hispanic ❑Not Latino/Hispanic ❑Unknown/Not Reported

Name of Parent/Legal Guardian: ________________________ Relationship to Student: ____________

Student's Street Address: ________________________ City: ____________ Zip: ________

Home Phone: ________________ Work Phone: ________________ Student's Phone: ________________

EMERGENCY CONTACT Name: ________________ Phone: ________________ Relationship to student: ________

INSURANCE

Do You Have Medical Insurance? ❑Yes ❑No If No, would you like our help to enroll? ❑Yes ❑No

If Yes, What Type of Insurance: ❑Medi-Cal ❑Alameda Alliance ❑Blue Cross ❑Kaiser ❑HealthPAC ❑Other ❑ Private: ________

ID No: ________________

Do You Have Dental Insurance? ❑Yes ❑No If Yes, What Dental Plan: ________________ ID No: ________________

MEDICAL PROVIDER

Do You Have A Medical Provider? ❑Yes ❑No Medical Provider Name: ________________ Phone Number: ________

I/We have read & understand the services offered at the School Health Center as described below. I/We understand that the services authorized by my/our signature on this form are limited to routine health services & treatment, which may include, but are not limited to:

1) Diagnosis/treatment of minor and acute illnesses; first aid for minor injuries
2) Assistance with chronic (on-going) illnesses
3) Physical examinations for sports or pre-employment clearance
4) Immunizations
5) Laboratory services
6) Vision screenings
7) Over-the-counter and basic prescription medications
8) Behavioral/Mental Health counseling
9) Health education: nutrition, drug & alcohol abuse prevention, violence prevention, safe sex, sexually transmitted disease & pregnancy prevention
10) Referrals to specialty care as needed
11) During school-wide dental screenings, a licensed dental professional will examine your child's teeth and determine if they are in need of dental care. This screening does not include x-rays and does not replace an in-office dental examination. If a problem is found, you will need to make a follow-up appointment with your dental provider; or the school health center staff may be able to assist you with a dental appointment on-site.

PLEASE NOTE: California State Law (California Family Code 6924-6929) permits for the provision of certain services to adolescents, 12 years and older, with or without parental consent. These services include diagnosis and treatment of sexually transmitted infections, HIV counseling and testing, pregnancy counseling and testing, contraceptives, referrals for prenatal care, and mental health counseling in situations specified by the law.
Please list any services offered at the School Health Center you <u>DO NOT</u> want your child/ward to receive**:**

____

I/We understand that this consent covers only those services provided at the School Health Center and no other private or public health facility. I/we hereby authorize a physician and other professional Health Center staff to provide necessary and/or advisable treatment for my child/ward. This student has my/our permission to receive all services offered at the School Health Center, except those that I/we have specifically excluded above.
Medi-Cal: Students may be asked to register for Medi-Cal at the Health Center. In some instances family income may be a factor in determining eligibility; eligibility may depend on the type of medical, dental or mental health service utilized by the student.
Medical Records: Medical records will be kept confidential. However, I/we acknowledge that the services for my child/ward's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School Health Center may be required to release information regarding treatment to third-party payers, such as Medi- Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt themselves; (2) If a student expresses they may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing them. I/We understand that I/we (1) have the right to receive a copy of this authorization. (2) I/we have the right to withdraw permission for the release of my information. If I/we sign this authorization to use or disclose information, I/we can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed. (3) I/We understand that

signing this authorization voluntarily and treatment, payment, or eligibility for benefits for my child/ward will not be affected if I/we do not sign this authorization. (4) I/We further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained or unless such disclosure is specifically required or permitted by law. *In order to improve our services, we are participating in a County-wide evaluation of School-Based Health Centers. The evaluation is being conducted by the University of CA, San Francisco (UCSF). As part of this evaluation, we collect information on the students who use our services. This information is shared with UCSF in aggregate (group) form without names or personally identifying information. We will not share your child/ward's personal information with the evaluators without your permission. By signing this form, you are agreeing to your child/ward's participation in this evaluation.*

Student Medical History

1. When was the child's last visit to the physician? ❑ Less than 6 months ❑ 6 months to 1 year ❑ More than 1 year
2. Does your child have *asthma*? ❑ Yes ❑ No If yes, are you interested in the asthma education program? ❑ Yes ❑ No
3. Is this child currently taking any type of *medications*? ❑ Yes ❑ No
   If yes, please write the name of each medication and tell what it is for: ______
4. Does this child have any *allergies to Medication*? ❑ Yes ❑ No
   If yes, please write the name of each medication child is allergic to: ______
5. Does this child suffer from *allergies (due to certain foods, pollen, grass, etc. -sneezing, itchy eyes, rash)?* ❑ Yes ❑ No
   If yes, please list what allergies the child has: ______
6. Has this child ever been to a dentist? ❑ Yes ❑ No
   When was the child's last visit to the Dentist? ❑ Less than 6 months ❑ 6 months to 1 year ❑ More than 1 year

I/We have completed the attached medical history form to the best of my/our knowledge.

This consent form *will remain in effect until this student's enrollment terminates, or until I/we revoke this contract in writing*.

Consent for Treatment and Notice of Free Choice of Pharmacy

(As required by the California State Department of Health) The undersigned patient or responsible relative/person hereby authorizes LifeLong Medical Care and its affiliated physicians and ancillary providers to administer and perform necessary behavioral health/medical/dental examinations, treatment and diagnostic procedures, including emergency care.

______ ______
Print Name of Parent/Legal Guardian Relationship to Student

______ ______
Signature Parent/Guardian Date

(As required by the U.S. Department of Health and Human Services, Resources and Services Administration (HRSA) and the State of California)
I hereby acknowledge that I am free to choose a pharmacy. Any fax/electronic transmission of my prescriptions shall be only to the pharmacy/dispensary I select. If I am eligible for medications through a free/discount pharmacy program, I will be directed to a specific dispensary/pharmacy. Lifelong will only offer free/discounted medications at certain contracted pharmacies. If I elect not to use the contracted pharmacy, I may have that prescription filled at another pharmacy, at my own expense.

______ ______
Signature Parent/Guardian Date

Medical Release Form

By signing below you are consenting to the following: I authorize the School District to grant, LifeLong Medical Care the on-site provider at this school, authorization to review my child/ward's pupil records. LifeLong Medical Care agrees not to disclose the pupil's records to any other person or entity without first obtaining my written permission. I also hereby authorize LifeLong Medical Care's School-Based Health Center staff and providers to exchange information concerning my child for the purpose of medical evaluation and treatment.

______ ______
Signature Parent/Guardian Date

______ ______ ______
Address of Parent/Legal Guardian (if different from student) City Zip

Summary Notice of Privacy Practices & Acknowledgement Form

I acknowledge that I have received a copy of LifeLong Medical Care's Notice of Privacy Practices

______ ______
Signature Parent/Guardian Date

Please return this form to the School Health Center or School's Main Office. Please call us if you have any questions.

East Oakland–Elmhurst United: 510-639-1479 ● West Oakland – WOMS/MLK Jr: 510-874-7272 ● Emeryville – Emery Secondary/Anna Yates 510-833-7050