NAME_____
SCHOOL_____
TEACHER_____ Grade_____

CONSENT FORM

In order for your child to receive services with HEALing Community Center at Lenora P. Miles Elementary or Hollis Innovation Academy, this consent form must be completed, and proper documentation of insurance obtained. Please complete all sides of this consent form. Please initial the area for acknowledgment of receiving the clinics' Notice of Privacy Policies.

I hereby voluntarily give my consent for _____ to receive healthcare
Name of Child
services with HEALing Community Center at Lenora P. Miles Elementary or Hollis Innovation Academy. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care.

I understand that my signing this consent allows the physician and professional clinic staff of **HEALing Community Center at Lenora P. Miles Elementary or Hollis Innovation Academy** to provide comprehensive health services **which includes physical, behavioral, and dental health services.** I authorize periodic dental examinations for my child, which may include photographs, radiographs, fluoride treatment, and any other acceptable methods for the dental evaluation and management of my child's dental health.

I authorize release of information from my son or daughter's medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services. I also authorize the Clinic to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale**. No patients will be denied services because of inability to pay.**

Finally, I give consent to share my child's health information between the school nurse and the school-based health center in order to obtain information needed to provide the best healthcare possible.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at **404-564-7749**. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

I understand that by typing my name in the signature box, I am electronically signing this document and agreeing to be legally bound by its terms and conditions.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

_____	_____	_____
Name of Patient (PLEASE PRINT)	**Date of Birth**	**Date**
_____	_____	_____
Parent or Legal Guardian (PLEASE PRINT)	**Parent or Legal Guardian (PLEASE SIGN)**	**Date**

Revised 8/12/2022

NAME_____
SCHOOL_____
TEACHER_____ **Grade**_____

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order for your child to receive services from the Health Clinic. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Today's Date: _____

Patient's Name_____ _____ _____
First Middle Last

Date of Birth _____ **Social Security Number**_____-_____-_____ **Sex**_____

Language □ English □ Spanish □ Sign Language □ Patient declined □ Other _____

Race □ Black/African American □ White/Caucasian American □ Asian □ Native American □ Alaskan □ Hawaiian □ Other _____

Special Education: ☐ Yes ☐ No **Email address**_____

Home Phone #_____ **Cell Phone #** _____ **Work Phone #** _____

Consent to receive texts? ☐Yes ☐ No **Consent to access the Patient Portal?** ☐Yes ☐No

Address_____**Apt.#**_____

City _____ **State** _____ **Zip** _____ **Birth Country** _____

How long at present address? ____Years ____Months **How long at previous address?** _____Years _____Months

Is present housing: ☐Permanent ☐Temporary ☐ Shelter ☐ Institution ☐None ☐Unstable ☐Foster Care ☐Other

Who lives with student: Please list everyone who lives in home including yourself:

NAME	RELATIONSHIP	AGE

Family size: _____ | **Income: $**_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually ☐ Choose not to disclose

Marital status of guardian: _____Married _____Single _____Widowed _____Divorced _____Separated _____Unknown

Emergency Contact Name _____ Relationship to Patient_____
Phone Number _____

Does anyone in the home smoke cigarettes or use tobacco products? ☐Yes ☐No

==========

WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE?

PLEASE PROVIDE PROOF OF INSURANCE OR YOU MAY BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. PLEASE LIST ALL INSURANCE COVERAGE THE CHILD IS ELIGIBLE FOR.

Name of Policy Holder/Guarantor _____ Date of Birth _____ Relationship to Patient_____

Primary Insurance Name_____ Policy #_____ Group #_____

Secondary Insurance Name _____ Policy # _____ Group#_____

_____No Insurance

You may be eligible for free insurance. Would you be interested in someone contacting you regarding this "free" insurance? ☐**Yes** ☐ **No**

Revised 8/12/2022

NAME_____
SCHOOL_____
TEACHER_____ Grade_____

General History

Does the patient have any allergies to medications, food and /or anything else?
List here _____
Reactions_____

Please List Daily Medication Names and Dosages

_____
_____
_____

Any Health Problems Under Treatment? ☐ Yes ☐ No. *If yes*, explain_____
Specify where treatment is being received _____

Has your child seen a doctor in the last year? ☐ Yes ☐ No

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

Where? _____

Why? _____

Has your child used a Hospital Emergency Room in the last year? ☐ Yes ☐ No

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

Where? _____

Why?_____

Was your child in the hospital overnight in the last year? ☐ Yes ☐ No

Where? _____

Why? _____How Long_____

Where does your child typically receive Primary care/Routine care? What Pharmacy do you use? In the cells below, please fill in names, addresses and phone numbers.

	PROVIDER/CLINIC NAME	ADDRESS	PHONE NUMBER
PRIMARY CARE/ROUTINE CARE			
PHARMACY			

Family History
Is there any family history of medical conditions (ie: high blood pressure, diabetes, asthma, seizures, tumors, etc)?
If so, please list the medical condition and specify who has or had the condition listed, in relation to the patient.

Family abbreviations: Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U.

DISEASES or CONDITIONS	WHO
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Revised 8/12/2022

NAME_____
SCHOOL_____
TEACHER_____ Grade_____

CHILD'S MEDICAL HISTORY

Please check YES for any health conditions that your child has or had in their lifetime. For Behavior Health and Dental questions, please check YES if your child has been experiencing these issues in the last 12 months.

ILLNESS HISTORY

Allergies	□Yes
Allergic to drugs	□Yes
Anemia	□Yes
Asthma	□Yes
Other Respiratory Problems	□Yes
Stomach Ulcers	□Yes
Abdominal Pain	□Yes
Constipation/Diarrhea	□Yes
Serious Digestive Problems	□Yes
Chicken Pox Age____	□Yes
Ear Problem	□Yes
Ear Infections	□Yes
Hearing Aid	□Yes
Eye Problem	□Yes
Wears Glasses	□Yes
Physical/Sexual Abuse	□Yes
Fainting Spells/Knocked Out	□Yes
Frequent Sore Throat	□Yes
Headaches	□Yes
Heart Murmur	□Yes
Heart Problems	□Yes
High Blood Pressure	□Yes
Thyroid Problems	□Yes
Diabetes	□Yes
Hepatitis	□Yes
Injuries (major)	□Yes
Musculoskeletal Problems	□Yes
Broken Bones	□Yes
Problems Walking	□Yes
Kidney/Urinary Tract Problems	□Yes
Frequent Colds	□Yes
Lung Problems	□Yes
Meningitis	□Yes
Menstruation Started Age_____	□Yes
Menstrual Problems	□Yes
Premature Birth Weight_____	□Yes
Obese	□Yes
Skin Rashes	□Yes
Serious Acne	□Yes
Sickle Cell Disease	□Yes
Sickle Cell Trait	□Yes
Other Blood Disorders	□Yes
Seizures/Epilepsy	□Yes
Speech Problem	□Yes
Tuberculosis	□Yes
Cancer	□Yes
Other_____	□Yes

BEHAVIOR HEALTH

Alcohol use	□Yes
Bedwetting	□Yes
Depression	□Yes
Disciplinary problems	□Yes
Drug use	□Yes
Eating problems	□Yes
Hyperactive/Overactive	□Yes
Learning Disability	□Yes
Frequent nightmares	□Yes
Shy	□Yes
Sleeping problems	□Yes
Smoking or inhalant use	□Yes
Thumb or finger sucking	□Yes
Other Behavior Problems	□Yes
Other Mental Problems	□Yes
Other_____	□Yes

Explain any behavior or mental problems noted _____

_____

_____

PLEASE LIST ANY PRESENT CONCERNS:

_____

_____

_____

***Explain any illnesses marked yes:

_____

_____

_____

_____

DENTAL

Dental Problems	□Yes
Pregnant	□Yes
AIDS/HIV	□Yes
Rheumatic Fever	□Yes
Hemophilia	□Yes
Underweight	□Yes

When was your child's last dental visit?

_____

Generally speaking, what has been your child's dental experience?

□Good □Bad □Very Bad □No prior experience

How often are your child's teeth brushed?

□Occasionally □Once a Day □Twice a day □Other

Has your child had a toothache recently? □Yes □No

Has your child had any injury to the teeth or jaws? □Yes □No

Revised 8/12/2022

NAME_____
SCHOOL_____
TEACHER_____ Grade_____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

□Spouse_____

□ Child(ren)_____

□ Other relatives_____

□ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

□ my home _____

□ my work_____

□ my cell number:_____

□ other number:_____

If unable to reach me:

□ you may leave a detailed message

□ please leave a message asking me to return your call

□ other _____

The best day to reach me is _____between_____ am/pm & _____am/pm

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

I understand the **HEALing Community Center** is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations. If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness. I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I HAVE RECEIVED THE HEALing Community Center SCHOOL HEALTH CLINIC'S NOTICE OF PRIVACY PRACTICES.

_____ _____

(PLEASE INITIAL) **(DATE)**