HEALTH SERVICES, INC.
Innovating Quality Patient Care.™

STUDENT GENERAL CONSENT

These forms are being requested by Health Services, Inc. The Montgomery Public School System does not condone or endorse the solicitation of any information that may be requested.

I understand that necessary and advisable health care services will be provided by qualified health care professionals and that my son/daughter is eligible to receive these services.

I understand that the following services will be available:

- Assessment and treatment for minor injuries.
- Assessment and treatment for minor illnesses (including providing appropriate over-the-counter medications such as Tylenol or Advil for simple concerns such as headache, cramps, etc.)
- Physical exams for school, sports and employment.
- Collaboration with the school nurse in the care of certain chronic conditions, such as asthma
- Follow-up examinations as requested by family physician or health care provider.
- Routine lab tests, as deemed medically necessary.
- Immunizations.
- Prescriptions.
- Dental screenings, examinations, sealants, and dental referrals.
- Visual examinations and referrals.
- Behavioral health services, such as individual and group counseling.
- Counseling for students regarding nutrition, personal hygiene, family and relationship issues, human growth and development and other health related issues.

I understand that all services are confidential. I understand that only Health Services, Inc. will have access to the student's medical chart, and that medical records or information from medical records cannot be released without the written consent of the patient and/or parent except that Health Services, Inc. is required to make such records available upon request from the Medicaid program or other payer in order to document the extent of services billed. Furthermore, I understand that information obtained by health professionals at Health Services, Inc. will not routinely be shared with the principal, guidance counselors, teachers or other staff. I understand that Health Services, Inc. will collaborate with the school nurse, to receive health information detrimental to the health of the child (for example, medication allergies and significant past medical history).

I understand that Health Services, Inc. will bill Medicaid and/or any other insurance carrier providing coverage for the student.

I understand that my consent is required by Health Services, Inc. before my child can receive services. I understand and have been provided with a copy of the Health Services, Inc. Notice of Privacy Practices that provides a more complete description of the uses and disclosures of the student's health information.

In order for my child to receive health care services at Health Services, Inc. School Based Health Center: (1) I authorize the nurse, or other designated health care professionals, to provide necessary and/or advisable assessment and treatment for the above named student. (2) I give permission for necessary medical tests and treatments. (3) I further release and hold harmless the Montgomery Public Schools

Board of Directors and do give, grant and release from any and all liability, costs or loss which my child may sustain or incur now, or at any time in the future or as a direct or indirect result of any treatment, consultation or other action or inaction by Health Services, Inc.

☐ I hereby give permission for my child _____ to become a patient of
Student's Full Name (Please Print)

Health Services, Inc. (HSI) or be treated in the HSI School Based Health Center.

☐ I DO NOT give permission for my child to become a patient of Health Services, Inc. (HSI) or be treated in the HSI School Based Health Center.

Parents/Guardian:

_____ _____ _____

Signature Date Date of Birth

☐ Verbal Consent obtained by _____
(Signature)

Witnessed by: _____
(Signature)

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Please circle one of the following HSI School Based Health Centers:

Bellingrath SBHC **Highland Gardens SBHC** **Davis SBHC** **Chisholm SBHC**

Child's Full Name: _____ DOB: _____ Sex: _____
First Middle Last

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: ( ) _____ Social Sec. #: _____

Ethnicity (Enia): ☐Hispanic or Latino **Race (Raza)** ☐Native Hawaiian ☐Other Pacific Islander ☐Asian ☐Black/African American ☐White ☐More than one race

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Parent or Legal Guardian: _____ DOB: _____

Name of Employer: _____ Work Number: _____

Cell Phone Number: _____Email address: _____

Emergency Contact: _____ DOB: _____

Address: _____ Contact Number _____

May we leave messages via phone and/or email? Phone ☐Yes ☐No Email ☐Yes ☐No

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated

Ethnicity (Enia): ☐Hispanic or Latino **Race (Raza)** ☐Native Hawaiian ☐Other Pacific Islander ☐Asian ☐ Black/African American ☐White ☐More than one race

Homeless Status (if applicable): ☐Doubling Up ☐Shelter ☐Street ☐Transitional Other_____

Insurance Information:

Primary Insurance: _____

Name of Policyholder: _____ Relationship to patient/child_____

Policy Holder Date of Birth: _____ Social Sec. #:_____

Contact/Member ID#:_____ Group#:_____

Secondary Insurance: _____

Name of Policyholder: _____ Relationship to patient/child_____

Policy Holder Date of Birth: _____ Social Sec. #:_____

Contract/Member ID#:_____ Group#:_____

Please place a check mark if you **do not** have insurance to cover this student: ☐

_____ I hereby understand that any amount not paid by the insurance company, that I will be
Initial responsible for full payment.

Financial Verification Self-Pay ☐ I **DO NOT** wish to provide income documentation and understand that I will not receive discounts.

(Patient+ spouse+ dependents)	Source of Income (Employer, SSI, Food Stamps, etc.)	Income Amount
1.		**$**
2.		**$**
3.		**$**
4.		**$**
5.		**$**

Expiration Date: _____ **Total Household Income: $_____**

I hereby agree that the information given relative to my legal residence and financial condition as recorded in my presence upon this form is true and that it may at any time be verified by an authorized investigator.

_____ I have received a copy of the income information sheet and its requirement to return financial
Initial proof in order to qualify for sliding fee discounts and I assume responsibility for all fees for service for myself and those for whom I am responsible.

_____ I acknowledge that I have received a copy of the Patient Bill of Rights, Notice of Privacy
Initial Practices, Primary Care Medical Home Information Sheet and Advanced Directive Sheet.

_____ I DO NOT want my medical or financial information discussed without my approval.
Initial

Please provide the list of names and date of birth for the individuals you wish to be given any, and all of your medical or financial information or who may accompany my child/children for treatment

	Name	Date of Birth	Phone
1.			
2.			

Signature of Patient_____ Date: _____

Signature of Policyholder: _____ Date: _____

Signature of Claimant: _____ Date: _____

Witness: _____ Date: _____
(HSI Patient Representative)

Please complete this information to register your child with the Health Services, Inc. School Based Health Center.

1. Child's Name: _____ DOB: _____ Age:_____
2. Grade in school (circle one): Preschool or Kindergarten
   1 2 3 4 5 6 7 8 9 10 11 12
3. Where do you take your child when he or she is ill? (Check the ones that apply)
   Private Doctor? ☐ Name of Doctor: _____
   Clinic: _____
   Hospital Emergency Room? ☐ Name of Hospital: _____
   Other? ☐ Please explain: _____
4. Has your child seen a doctor in the last year? ☐ Yes ☐ No
   Why? _____
5. Has your child used a Hospital Emergency Room in the last year? ☐ Yes ☐ No
   Why? _____
6. Was your child in the hospital overnight in the last year? ☐ Yes ☐ No
   Why? _____
7. Does your child have any of these problems?

   ☐ Asthma (trouble breathing) ☐ Frequent ear infections ☐ Problems sleeping

   ☐ Stomach problems ☐ Frequent headaches ☐ Skin problems

   ☐ Hearing problems ☐ Frequent colds bad enough to miss school

   ☐ Other: (explain) _____

8. Is your child allergic to any foods? ☐ Yes ☐ No
   If yes, please explain: _____
9. Has your child ever had an allergic reaction to medication? ☐ Yes ☐ No
   If yes, please explain: _____
10. List any prescription medications your child presently takes.
    _____
    _____
    _____
    _____

11. Has your child had chicken pox? ☐ Yes ☐ No
12. Is your child currently seeing a specialist? ☐ Yes ☐ No
13. If yes, give specialist's name: _____