# Lakeview Health Center

## Consent for Treatment

2014-2015 School Year

| Student's First Name: | Middle Initial: | Last Name: | Date of Birth: | Grade: |
|---|---|---|---|---|
| | | | | |

The Lakeview Health Center (LHC) is available to provide health care services for students. It is necessary for you and your student to sign this form for your student to receive health care from the LHC. The services are provided by staff of the Calhoun County Public Health Department (CCPHD). The consent begins on the date signed and will remain effective for the duration of enrollment in Lakeview School District or Calhoun Community High School. However, you will be asked to update health forms and consent yearly. Consent may be withdrawn at any time through written notification. The following services are available with consent:

- Treatment for minor health problems/injuries
- Over-the-counter medication administration such as Acetaminophen (Tylenol), Ibuprofen (Advil), cough drops, eye drops, throat lozenges, chewable antacids, and ointments such as Triple Antibiotic, Benadryl and Hydrocortisone, & Anti-Fungal cream
- Prescriptions for minor health problems/illnesses
- Lab tests for minor illnesses (ie: strep throat, urine screening)
- Monitoring of chronic illnesses (ie: random blood glucose testing, spirometry for asthma evaluation, Cholestech for unhealthy weight, hemoglobin for anemia)
- Treatment of chronic illnesses (ie: nebulizer treatment for acute asthma attacks)
- Mental Health Services
- Immunizations (with additional consent form)
- Physicals for sports, camp, school or work (available by appointment/additional forms needed)
- Health education
- Basic emergency care
- Evaluation & monitoring for unhealthy weight

I understand that testing for blood borne diseases, including HIV/AIDS, may be performed upon a student without separate written consent in the event that a health care professional from the LHC sustains exposure to blood or body fluids from the student's open wound, skin, mucous membrane or occupational hazard.

***No birth control pills or devices are dispensed or prescribed at the LHC. The student will be given a referral list of community agencies that provide these services. No abortion counseling, referrals or services are provided.***

I understand that minors may, without parental consent, receive advice, testing and/or treatment for drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services. There is no specific age set forth in the law. This applies to any minors who understand the nature and consequences of their actions.

I further understand that a minor 14 years of age or older can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. I understand that the social worker treating the student may notify the parent/guardian, without student permission, if someone is hurting the student, the student is hurting himself or someone else, the student plans to hurt himself or someone else, or if it is seen to be in the best interest of the student. In this case, the social worker will try to notify the student of their duty to inform the parent/guardian prior to discussion.

**Consent for Treatment** – I give my permission and agree that the above services may be administered by the LHC in accordance with established protocols developed by the CCPHD, including restrictions on disclosure of medical records. I further consent to release of information to my child's primary care provider regarding follow-up care for treatment provided.

*I have received a copy of the CCPHD Privacy Notice & Client Rights & Responsibilities*

| **I verify that I am authorized to sign the consent for the student listed above.** | |
|---|---|
| Parent/Guardian Signature: | Date: |
| Student Signature: | Date: |

**As with all medical records, the Lakeview Health Center records are kept confidential consistent with applicable law. Access to these records is not permitted without the consent of the student. In a medically-appropriate situation, pertinent information will be given to the parent/guardian and/or others as permitted or required by law.**

# Lakeview Health Center Registration Form

## 2014-2015 School Year

**STUDENT INFORMATION**

| First Name: | Middle Initial: | Last Name: | |
|---|---|---|---|
| Date of Birth: | Sex: ☐Male ☐Female | Grade: | Home Phone #: |
| Street Address: | | | |
| City: | State: | Zip Code: | |

**PARENT/GUARDIAN INFORMATION**

| Mother/Guardian: | Hm#:<br>Cell#: | Wk#: |
|---|---|---|
| Father/Guardian: | Hm#:<br>Cell#: | Wk#: |

**EMERGENCY CONTACT INFORMATION**

| Emergency Contact Name: *(other than parent—parent always contacted first)* | Relationship: |
|---|---|
| Hm#:_____ Cell#:_____ Wk#: _____ | |

STUDENT ETHNIC BACKGROUND (*Please Check All That Apply*)

☐American Indian/Alaskan Native ☐Arabic ☐Asian ☐Black/African American
☐Hispanic/Latino ☐Native Hawaiian ☐Other Pacific Islander ☐White

**HEALTH INSURANCE**

Does the student have Medicaid or other health insurance? ☐YES ☐NO
If **yes**, please complete the boxes below.

| Contract #/Policy #/Medicaid #: | Group #: |
|---|---|
| Insurance Name: | Effective Date: |
| Insurance Billing Address:<br><br>*Please provide a copy of the front and back of the insurance card.* | |

**SUBSCRIBER INFORMATION *(name on insurance card)***

| Name: | Date of Birth: |
|---|---|
| Sex: ☐Male ☐Female | Employer: |
| Relationship to Student: (*please check one*)<br>☐Father ☐Mother ☐Guardian ☐Step-Parent ☐Grandfather ☐Grandmother<br>☐Other: *(please list)*_____ | |

**Does the student have a secondary health insurance?** ☐YES ☐NO

If **yes**, please provide the above information for the secondary insurance along with a copy of the front and back of the insurance card. The above information can be written on the copy of insurance card.

**CONSENT FOR BILLING – I hereby authorize Lakeview Health Center to bill my insurance company and release related information necessary to complete the billing process for services provided.**

| Parent/Guardian Signature:<br><br>***(MUST BE IN BLACK/BLUE INK--red ink and pencil cannot be accepted.)*** | Date: |
|---|---|

**LAKEVIEW HEALTH CENTER HEALTH INFORMATION**
**2014-2015 School Year**

| **Student's Name**: | **Date of Birth**: |
|---|---|
| Doctor's Name:<br>Date of last Physical: | Dentist's Name:<br>Date of Last Exam: |

**ALLERGIES** ***(List and describe allergies.)***

| |
|---|
| To Medication/Drugs: |
| To Foods/Plants/Animals/Insects/Other: |
| Does student use/need an Epi-Pen for emergency treatment of an allergic reaction? ☐YES ☐NO |

**MEDICATION TAKEN ON REGULAR BASIS**

| Name of Medication | Condition Med Used For | Dosage Taken | Frequency Given |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**INJURIES/SURGERIES/HOSPITALIZATIONS/ILLNESS** ***(List all injures, in-patient/out-patient surgeries, hospitalizations and severe illnesses.)***

| Description of Injury/Surgery/Illness | Age | If hospitalized, please explain |
|---|---|---|
| | | |
| | | |

**HEALTH CONDITIONS** ***(Check conditions student has currently or has had in the past.)***

| History | YES | NO | History | YES | NO | History | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ADHD | | | Emotional/Behavioral | | | Pregnancy | | |
| Anemia | | | Eye Problem/Poor Vision | | | Rheumatic Fever | | |
| Asthma | | | Headaches/Migraines | | | Scoliosis | | |
| Autism | | | Frequent Sore Throats | | | Seizures | | |
| Birth Defect(s) | | | Hearing Aids | | | Sickle Cell /Blood Disorders | | |
| Blood Pressure Problems | | | Hearing Problems | | | Sleeping Problems | | |
| Broken Bones | | | Heart Disease | | | Special Education | | |
| Cancer, Type: | | | Hemophillia | | | Speech Difficulty | | |
| Chronic Ear Infections: | | | Hepatitis/Type: | | | Sports Injuries Type: | | |
| Depression | | | Juvenile Arthritis | | | Substance Abuse | | |
| Diabetes | | | Kidney Disease | | | Suicide Attempt | | |
| Diarrhea/Constipation | | | Meningitis/Encephalitis | | | Toothache/Dental Problems | | |
| Digestive Problems/Ulcer | | | Menstruation Problems | | | Bladder/Kidney Infection | | |
| Eating Disorder | | | Muscle Problems | | | Tuberculosis | | |
| Eczema/Skin Problems | | | Nose Bleeds | | | Mononucleosis | | |

For all boxes marked **Yes**, please explain.

_____

**FAMILY HISTORY**

| | None | Mother | Father | Sister/Brother | Grand-Parent |
|---|---|---|---|---|---|
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression/Suicide | ☐ | ☐ | ☐ | ☐ | ☐ |
| Type II Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Attack/Sudden Death before the age of 50 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |

**Parent/Guardian Signature** _____ **Date** _____

# Lakeview Health Center

## Parent/Guardian Concerns

### 2014-2015 School Year

**With whom does the adolescent live most of the time? (Check all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Both parents in the same household | ☐ | Stepmother | ☐ | Sister(s) ages_____ |
| ☐ | Mother | ☐ | Stepfather | ☐ | Other |
| ☐ | Father | ☐ | Guardian | | |
| ☐ | Other adult relative | ☐ | Brother(s) ages _____ | | |

**In the past year, have there been any changes in your family? (Check all that apply)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Marriage | ☐ | Loss of Job | ☐ | Births | ☐ | Other |
| ☐ | Separation | ☐ | Move to new neighborhood | ☐ | Serious Illness | ☐ | Move to new school |
| ☐ | Divorce | ☐ | Death | | | | |

**Please review the topics listed below. (Check if you have a concern about your adolescent)**

| | | | |
|---|---|---|---|
| ☐ | Physical problems | ☐ | Guns/weapons |
| ☐ | Physical development | ☐ | School grades/absences/dropout |
| ☐ | Weight | ☐ | Smoking cigarettes/chewing tobacco |
| ☐ | Change of appetite | ☐ | Drug use |
| ☐ | Sleep patterns | ☐ | Alcohol use |
| ☐ | Diet/nutrition | ☐ | Dating/parties |
| ☐ | Amount of physical activity | ☐ | Sexual behavior |
| ☐ | Emotional development | ☐ | Unprotected sex |
| ☐ | Relationships with parents & family | ☐ | HIV/AIDS |
| ☐ | Choice of friends | ☐ | Sexually transmitted diseases (STD'S) |
| ☐ | Self image or self worth | ☐ | Pregnancy |
| ☐ | Excessive moodiness or rebellion | ☐ | Sexual identity (heterosexual/homosexual/bisexual) |
| ☐ | Depression | ☐ | Work or job |
| ☐ | Lying, stealing or vandalism | ☐ | Violence/gangs |
| ☐ | Other _____ | | |

**What seems to be the greatest challenge for your teen?**

**What is it about your teen that makes you proud of him or her?**

**Can we share your answer to this question with your teen?** ☐YES ☐NO

**Is there something on your mind that you would like to talk about with the health center staff? What is it?**

**Parent/Guardian Signature** _____**Date:**_____