PATHS
Live Life. Be Healthy.

Services Offered by PATHS School-Based Health At Your School

- Annual Wellness Exams
- Sports Physicals
- Sick Visits
- Labs
- Immunizations
- Prescriptions
- Dental Exams
- Vision Care

NAME: _____ _____ _____

Gender Identity ☐ Male ☐ Female ☐ Transgender/Male to Female ☐ Transgender/Female to Male — Student Date of Birth — Grade

☐ Genderqueer, neither exclusively male or female ☐ Choose Not to disclose — Student School: _____

_____ _____ _____ _____

Mailing Address — City — State — Zip Code

Lives with ☐ Father ☐ Mother ☐ Both ☐ Other: _____ Do you live in public housing? ☐ Yes ☐ No ☐ Homeless

Are you a Student? ☐ **Yes** ☐ **No** Are you a veteran? ☐ Yes ☐ No How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In person

Race (**check all that apply**):☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Japanese ☐DECLINE

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ DECLINED to specify **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____ **Interpreter Needed**: ☐ Yes ☐ No

Accessibility Needs: ☐ Hearing Impaired ☐ Vision Impaired

PARENTS/LEGAL GUARDIANS

Parent of Legal Guardian Name — Phone# (Home or Cell) — Phone # (Work) — Email Address

Parent of Legal Guardian Name — Phone# (Home or Cell) — Phone # (Work) — Email Address

RESPONSIBLE PARTY (REQUIRED)

Name_____ Phone#_____

Relationship to patient: _____ Birthdate: _____ SS#_____

_____ _____ _____ _____

Address — City — State — Zip

Is this person also a patient enrolled in other PATHS services? ☐ Yes ☐ No

INSURANCE INFORMATION

Please **check all** that apply and send in a copy of the insurance card(s)

☐ **HEALTH INSURANCE** (Private insurance, Medicaid, ID Number/Policy Number, etc.) ☐ **NO HEALTH INSURANCE**

Name of Insured: _____ Relationship to Patient_____ Birthday: _____

PRIMARY Insurance Company — ID/Policy Number — Group Number

Do you have prescription coverage? ☐ **Yes** ☐ **No**

Name of Insured: _____ Relationship to Patient_____ Birthday: _____

SECONDARY Insurance Company — ID/Policy Number — Group Number

Do you have prescription coverage? ☐ **Yes** ☐ **No**

HEALTH INFORMATION

Doctor's Name_____ Current Medications _____

Please check √ the following services you would like for your child to have during the current school year in the School-Based Health Center:

☐ **Annual Wellness Exams** ☐ **Sports Physicals** ☐ **Sick Visits** ☐ **Immunizations** ☐ **Labs** ☐ **Prescriptions** ☐ **Dental Exams** ☐ **Vision Care**

EMERGENCY CONTACT

_____ _____

Name — Relationship

_____ _____ _____ _____

Address — City — State — Zip

(___)_____ (___)_____ (___)_____

Phone: Home — Phone: Cell — Phone: Work

I authorize PATHS School-Based Health to leave messages related to my care on my answering machine/voicemail ☐ Yes ☐ No

CONSENT FOR OVER-THE-COUNTER MEDICATIONS

NO Over The Counter Medications (OTC) will be given to a child who does not have a registration/consent on file for the current school year. I grant permission for the PATHS School-Based Health Center clinical staff to administer the following OTC medication to my child as he/she requests. I and my child understand that a total of only three OTC medications will be administered in the course of one school year. Frequent requests for OTC medications could suggest the need for an examination by a healthcare provider.

There are the OTC medications we may administer:

Tums (Antacid) • Cough Drops • Ibuprofen • Hydrocortisone Cream 1# • Tylenol Triple Antibiotic Cream

_____

Signature of Parent/Guardian **Date**

NOTICE OF PRIVACY PRACTICE/PARENTAL CONSENT

PATHS School-Based Health Notice of Privacy Practices are posted in the School-Based Health Center. Also, I may obtain a Notice of Privacy Practice by contacting the School-Based Health Center at (434) 791-0216. The Notice of Privacy Practice describes the types of uses and disclosures of your child's protective health information that might occur for their treatment, payment of their bills, or in the performance of PATHS School-Based Health Center operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your child's protected health information. I understand that PATHS School-Based Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the PATHS School-Based Health Center and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I, the parent/guardian of said student, give consent for him/her to receive health services. I understand those services may include nursing care, medical treatment, and referral for counseling; and that all healthcare information is confidential. I certify that I have been informed of the policies and procedures related to how PATHS School-Based Health Center, a division of Piedmont Access to Health Services, Inc., may use and /or disclose your child's personal health information.

By signing this consent form:

(1) I am authorizing my child to receive services in my absence;
(2) I am agreeing to accept the risks of medical procedures, medication(s), testing (including HIV), and other treatment;
(3) I am agreeing to abide by the PATHS procedures and patient responsibilities set out in this form;
(4) I am granting PATHS permission to bill my child's insurance for services provided.

I acknowledge that I have read this form or had this form read and explained to me, that I understand it and agree to its content. I agree to be truthful in providing information.

_____

Signature of Parent/Guardian **Date**