Services Offered by PATHS School-Based Health Care At Your School

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

NAME: _____ _____ _____

Student Date of Birth **Grade**

Gender Identity ☐ Male ☐ Female **Student's 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 or Legal Guardian Name | Phone# (Home or Cell) | Phone # (Work) | Email Address

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

RESPONSIBLE PARTY (REQUIRED)

Name_____ Phone#_____

Relationship to patient: _____ Birthdate: _____ Phone#_____

_____ _____ _____ _____

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 mark with a X any services you DO NOT wish for your child to receive at School-Based Health.

☐ **Medical Care** ☐ **Behavioral Health** ☐ **Dental Exams**

EMERGENCY CONTACT

_____ _____

Name Relationship

_____ _____ _____ _____

Address City State Zip

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

Phone: Home Phone: Cell Phone: Work

I authorize PATHS School-Based Health Care to leave messages related to my care via 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 Care 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 Ointment

_____

Signature of Parent/Guardian **Date**

NOTICE OF PRIVACY PRACTICE/PARENTAL CONSENT

PATHS School-Based Health Care Notice of Privacy Practices are posted at the School-Based Health Care Center. Also, I may obtain a Notice of Privacy Practice by contacting School-Based Health Care 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 Care 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 Care 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 PATHS School-Based Health Care 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 Care, 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 treatments;
(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.
(5) This consent remains in effect for the duration of my child's enrollment at _____.
(Name of School)
(6) I understand that I can revoke this consent at any time by submitting a request.

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**

PATHS
Live Life. Be Healthy.

Name: _____ **Date of Birth:** _____

Permission to evaluate and treat a minor without a parent/guardian present

I _____ (parent/guardian) give permission for my child _____ (child) to attend his/her apt with the following people. This includes bringing the child into the office of PATHS, providing a history of present illness, disclosing protected health information, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above.

Please note that this consent gives PATHS permission to **evaluate and treat** my child, which could include, but is not limited to vaccines, breathing treatments, in-office medications, labs (blood work) etc._____ (initial)

I fully understand that by signing this, I am providing PATHS with permission to **evaluate and treat** my child, as the provider deems necessary.

Adult	Phone Number	Relationship to Patient

Health Record Release Authorization (HIPAA)

I authorize disclosures of my health information, relevant to current treatment and to ***VERBALLY*** discuss medical and billing information about me/patient to the following people:

Adult	Phone Number	Relationship to Patient

_____ _____ _____

Signature of parent/guardian **Date** **Relationship to patient**

Please provide us with a phone number to reach you should we have any questions

_____

PATIENT MEDICAL INFORMATION

Name: _____ **DOB:** _____

List of Current Medications:

Name of Medication	Dosage/Strength	Taken How Often	Prescriber

List of all Allergies (Medication and other):

Medical Diagnosis/Health History:

Surgeries:
