Student Wellness Center

The Physician Network

Affiliate of Saint Francis Medical Center - Catholic Health Initiatives

CONSENT FOR SERVICES

Please **INITIAL** the boxes for the services you would like provided for:

Student's Name _____ Date of Birth_____

☐ I give my consent for the above named student to receive medical health services from any physician or physician designated health professional working for the Student Wellness Center.

☐ I give my consent for the above named student to receive mental health, behavioral health, and chemical dependency services offered by any physician or physician designated health professional working for the Student Wellness Center.

☐ I give my consent for urine or blood testing for detecting drugs and alcohol.

Appointment date and time will be shared with Grand Island Senior High for attendance purposes only. Additionally, I have read and understand the above statements. I also understand that additional information regarding the health services offered by the Student Wellness Center can be obtained by calling 384-2265.

☐ **BY INITIALING THIS STATEMENT I ACKNOWLEDGE RECEIPT OF THE PHYSICIAN NETWORK'S NOTICE OF PRIVACY PRACTICES RECEIVED IN THE SCHOOL REGISTRATION PACKET AND/OR RECEIVED AT INITIAL REGISTRATION WITH THE STUDENT WELLNESS CENTER. (version 4103)**

MEDICAL RECORDS RELEASE

I give my permission for the exchange of relevant verbal/written information between Student Wellness Center and:

☐ School Administration/ Personnel

☐ Probation / Diversion / Truancy Court

I give my permission for the exchange of relevant medical/behavioral health information (including information about physical exams, health histories and other information) between the Student Wellness Center staff and the school nurse, the student's primary care physician, or referral physician/facility as needed, in order to facilitate evaluation of this student's medical/behavioral health care.

Information disclosed to the above may be re-disclosed by the recipient and no longer protected by HIPPA privacy standards.

INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the Student Wellness Center to release information regarding treatment to third party payers or others for purposes of billing or program management and evaluation. Additionally, I authorize and request that any payment of benefits due for care provided be paid directly to the Student Wellness Center. I individually obligate myself and the patient to pay the account of The Physician Network in accordance with the regular rates and payment policy of the Medical Center. If you believe you qualify for charity assistance, please notify us.

_____

SIGNATURE OF PARENT/GUARDIAN DATE

Relationship to student: ❑ Mother ❑ Father ❑ Other (specify) _____

The Student Wellness Center will not provide any services to any student without a signed parental permission form, including services the clinic could legally provide without parental permission.

*This consent can be withdrawn at any time with written notification to the Student Wellness Center.
*This consent is good only for the current school year.

THIS SECTION FOR OFFICE USE ONLY.

Date Received_____ Date Verified _____ Verified by Whom _____ Revised 04-2013

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REGISTRATION AND CONSENT - DEMOGRAPHIC INFORMATION

*Student's Name_____ DOB _____ SSN _____

Address _____ Zip _____

Home Phone_____ Cell Phone _____

*Father's Name _____ DOB _____ SSN _____

Address _____ Zip _____

Home Phone_____ Cell Phone _____

Father's Work Name/Address _____

_____ Work Phone _____

*Mother's Name _____ DOB _____ SSN _____

Address _____ Zip _____

Home Phone_____ Cell Phone _____

Mother's Work Name/Address _____

_____ Work Phone _____

*Guardian Name _____ DOB _____ SSN _____

Address _____ Relationship to Student _____

Home Phone_____ Cell Phone _____

Guardian - Work Name / Address_____

_____ Work Phone _____

Insurance Information: Please provide a copy of your insurance card (front and back). Or fill out the following information completely. Otherwise you will be billed as self pay.

Policy Holder Name: _____ Relation to Student _____

DOB: _____ Marital Status: M S W D U.S. Citizen: ❑ YES ❑ NO

Insurance Carrier _____ Is this a PPO? ❑ YES ❑ NO

Insurance Address _____ State _____

Phone # _____ Effective Date _____

Policy or plan # _____ Group # _____

Does this insurance require a co-payment? ❑ YES ❑ NO Amount $_____ **CO-PAYMENT WILL BE COLLECTED AT TIME OF VISIT.**

Does this insurance require pre-authorization? ❑ YES ❑ NO If so, phone #_____

If student is covered by Medicaid / Medicare, please provide your Medicaid number_____

NO CHILD WILL BE DENIED SERVICES BECAUSE OF INABILITY TO PAY.

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This information is **STRICTLY CONFIDENTIAL**. Its purpose is to help you caregiver give you better care. We request that you fill out the form completely.

Student's Name: _____

Date of Birth:_____ Age: _____ Sex: M F Grade in school: _____

Race (circle all that apply)
American Indian/ Alaskan Native
Asian
Black/African American
Native Hawaiian
Other Pacific Islander
White
Decline to report

Ethnicity (circle one)
Hispanic/Latino
Non-hispanic/Non-latino
Decline to report

Primary Language
English
Spanish
Other_____

Interpreter for you?
❍ YES ❍ NO

Interpreter for family?
❍ YES ❍ NO

Please list all medications child is currently taking (Including prescription, over the counter medications, vitamins & mineral supplements and herbal remedies:

Name_____ Dose:_____ Frequency: _____

Name_____ Dose:_____ Frequency: _____

Name_____ Dose:_____ Frequency: _____

Please list any known allergies and reactions: _____

_____

_____

EMERGENCY CONTACT

Name_____ Relationship: _____

Address: _____ Zip: _____

Phone:_____Cell: _____ Work: _____

PRIMARY CARE PHYSICIAN

Name_____ Clinic Name:_____

Address: _____ Phone: _____

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MEDICAL HISTORY QUESTIONNAIRE

Date_____ Patient Name _____

Ethnicity _____ Sex M F Date of Birth:_____

Form Completed by:_____Informant (guardian, parent)_____

STUDENTS MEDICAL HISTORY

Has your student ever had:

Allergies (List) (Food or Medicine)	❍ YES	❍ NO
_____		
Asthma/Wheezing	❍ YES	❍ NO
Asthma Action Plan	❍ YES	❍ NO
Pneumonia	❍ YES	❍ NO
Chicken Pox (Year_____)	❍ YES	❍ NO
Frequent Ear Infections	❍ YES	❍ NO
Vision Problems	❍ YES	❍ NO
Hearing Problems	❍ YES	❍ NO
Skin Problems/Eczema/Hives	❍ YES	❍ NO
TB/Lung Disease	❍ YES	❍ NO
Seizures/Epilepsy	❍ YES	❍ NO
High Blood Pressure	❍ YES	❍ NO
Heart Defects/Disease	❍ YES	❍ NO
Liver Disease/Hepatitis	❍ YES	❍ NO
Diabetes	❍ YES	❍ NO
Kidney Disease	❍ YES	❍ NO
Bladder Infections	❍ YES	❍ NO
Menstrual Problems	❍ YES	❍ NO
Physical or Learning Disabilities	❍ YES	❍ NO
Bleeding Disorders/Hemophilia	❍ YES	❍ NO
Sexual Transmitted Infections	❍ YES	❍ NO
Emotional/Behavioral Problems	❍ YES	❍ NO
Depression/Suicidal Thoughts	❍ YES	❍ NO
Hospitalizations/Surgeries	❍ YES	❍ NO
Physical/Sexual Abuse	❍ YES	❍ NO
Emotional Abuse	❍ YES	❍ NO
Bone or Joint Injuries	❍ YES	❍ NO
Mobility/Coordination Problems	❍ YES	❍ NO
Dental Problems	❍ YES	❍ NO
Obesity/Overweight	❍ YES	❍ NO
Eating Disorders	❍ YES	❍ NO
Anorexia Nervosa	❍ YES	❍ NO
Bulimia	❍ YES	❍ NO
Learning Disabilities	❍ YES	❍ NO
Attention Deficit Disorder	❍ YES	❍ NO
Dental Exam	❍ YES	❍ NO
Seat Belt Use	❍ YES	❍ NO

Other Concerns:

*Hospital /Surgery, List and Year:

Reviewed by:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List) (Food or Medicine)	❍ YES	❍ NO
_____		
Asthma/Wheezing	❍ YES	❍ NO
TB/Lung Disease	❍ YES	❍ NO
Cystic Fibrosis	❍ YES	❍ NO
HIV/AIDS	❍ YES	❍ NO
Suicide Attempts	❍ YES	❍ NO
Heart Disease	❍ YES	❍ NO
Sudden Cardiac Death	❍ YES	❍ NO
High Blood Pressure/Stroke	❍ YES	❍ NO
High Cholesterol	❍ YES	❍ NO
Blood Disorders	❍ YES	❍ NO
Sickle Cell	❍ YES	❍ NO
Anemia	❍ YES	❍ NO
Thalassemia	❍ YES	❍ NO
Clotting Disorders	❍ YES	❍ NO
Diabetes	❍ YES	❍ NO
Seizures	❍ YES	❍ NO
Mental Illness	❍ YES	❍ NO
Depression	❍ YES	❍ NO
Suicide Attempts	❍ YES	❍ NO
Cancer	❍ YES	❍ NO
Breast	❍ YES	❍ NO
Cervical	❍ YES	❍ NO
Colorectal	❍ YES	❍ NO
Other_____	❍ YES	❍ NO
Birth Defects	❍ YES	❍ NO
Hearing Loss	❍ YES	❍ NO
Speech Problems	❍ YES	❍ NO
Kidney Disease	❍ YES	❍ NO
Alcohol/Drug Abuse	❍ YES	❍ NO
Hepatitis/Liver Disease	❍ YES	❍ NO
Thyroid Disease	❍ YES	❍ NO
Learning Problems	❍ YES	❍ NO
Attention Deficit Disorder	❍ YES	❍ NO
Mental Retardation	❍ YES	❍ NO
Family Violence	❍ YES	❍ NO

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50? ❍ YES ❍ NO

Explain:

Date of Review: