JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS
2020-2021 Enrollment/Consent Annual Update

Welcome back to school for the 2020-2021 school year! Please complete and return this form to update your child's medical records and renew your permission for them to continue receiving services at the School Based Health Center. **Please complete in Blue or Black ink.**

Name of Student: _____ DOB: _____ Age: ____ Grade: ____

Address: _____ City/State/Zip: _____

Student Email: _____ Student Phone: _____

Student Social Security #:_____

Parent/Guardian Name: _____

Phone #: (c) _____ (w) _____ Email: _____

Parent/Guardian Name: _____

Phone #: (c) _____ (w) _____ Email: _____

Emergency Contact Name: _____ Phone #:_____

Medical Clinic/Doctor/Primary Care Provider: _____

Have there been any changes to your child's **insurance coverage**, since last year? YES NO

If yes, please list: _____

PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT & BACK)

Is your child taking any daily **medications**? YES NO

If yes, name of medication and dose: _____

Does your child have any known **allergies**? YES NO

Please list: _____

Has your child been treated by a physician in an **emergency room** or his/her office for a serious illness or injury during the summer break? YES NO

List changes in family medical history in the past year._____

We (student and parent/guardian) have read and understand the services to be provided at the school-based health center. This student may continue to receive the services provided by the Jefferson Parish School Based Health Centers. The original Enrollment/Consent form is unaffected and shall continue in effect in accordance with its terms.

We understand that the SBHC may participate in one or more Health information exchanges (HIEs), whereby the center may share my health information with other Health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

A copy of the Jefferson Parish School Based Health Centers Notice of Privacy Practices is available upon request at the SBHC.

We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of School-Based Health Centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

_____ _____
Printed Name of Parent/Legal Guardian Relationship

_____ _____
Signature of Parent/Legal Guardian Date

This consent may be withdrawn or modified at any time with written request of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Student's Full Name:_____ **Date of Birth:**_____

Jefferson Parish Schools School Based Health Centers
Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a health care or mental health provider to deliver services to an individual when he/she is located at a different site than the provider.

I acknowledge that I have been notified of my right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may revoke my consent to telemedicine/telehealth services orally or in writing. As long as this consent is in force (has not been revoked) Jefferson Parish School Based Health Centers may provide health care or mental health services to me via telemedicine/telehealth without the need for me to sign another consent.

I understand that the laws that protect privacy and the confidentiality of medical/mental health information also apply to telemedicine/telehealth. I understand that as an existing patient of Jefferson Parish School Based Health Centers my health information will be used and disclosed in accordance with Jefferson Parish School Based Health Centers' Notice of Privacy Practices, a copy of which may be requested at any time. I understand that I can obtain copies of my medical or mental health records by contacting my provider's office. The clinic staff will release my records after they have received written authorization permitting the release of my medical or mental health records to my designated recipient.

I understand that in the event of a technology or equipment failure I should call my providers office to receive further instructions. I understand that telemedicine/telehealth is not used to provide emergency care and such emergency care should be sought by calling 911.

By signing below, you are acknowledging the above information and are consenting to receiving telemedicine/telehealth services from Jefferson School Based Health Center and its participating providers.

_____ _____

Signature of Parent/Legal Guardian (unless student is 18 years old or above) Date