ARBOR
FAMILY HEALTH
BRUSLY
SCHOOL BASED CLINIC

## Arbor Family Health School Based Health Centers are excited to welcome back students for the new school year!

Our school based health clinic can help children succeed by providing convenient access to healthcare, behavioral/mental health services, and dental services, all while reducing student absenteeism as well as parental leave form work.

We are located on the Brusly Middle School Campus!

School Based Health offers:

- Transportation to and from schools
- Well child visits, sports physicals, and preventative screenings.
- Immunizations
- Sick visits that can include in house diagnostic testing for flu, COVID-19, and strep
- Behavioral health services
- Pharmacy Services (pick-up, delivery, or mail order)
- Telehealth/virtual visits
- Outreach Coordinator to assist with insurance applications

In order for your child to receive any of our services, the attached consent must be completed in full and returned to school or to the clinic.

To schedule an appointment call: 225-385-2668.

For more information about our other services or any questions please call 1-888-711-3785.

We look forward to providing these services for your child!

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# Brusly School Based Health Center

## Consent for Transportation

I,__________________________________ (Parent/Guardian), give my permission for my child____________________________to be transported from their school to/and from:

Brusly Elementary School
400 South LaBauve Rd.
Brusly, LA 70719

Brusly Middle School
630 North Vaughn Dr.
Brusly, LA 70719

Brusly High School
658 North Vaughn Dr.
Brusly, LA 70719

Brusly Upper Elementary School
601 North Kirkland St.
Brusly, LA 70719

Lukeville Upper Elementary School
6123 LA Highway 1 South
Brusly, LA 70719

Brusly School Based Clinic
630 North Vaughn Dr.
Brusly, LA 70719

In an Innis Community Health Center (ICHC) van to receive medical/dental services during the school year.

**If you wish to revoke your consent for transportation at any time, please call the Brusly High School Based Health Center at 225-385-2668 or 225-344-0008.**

________________________
Child's Name (PRINT)

________________________
(Child's Date of Birth)

________________________
Parent or Guardian Name (PRINT)

________________________
Parent/Guardian Signature

________________________
(Child's School and Grade)

Cindy G. Peavy
Cindy Peavy, Executive Director

________________________
Date Signed

Wesley S. Watts
Wesley S. Watts, Superintendent

________________________
Date Signed

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# LOUISIANA UNIFORM CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS

Student's Name: Last | First | Middle Initial | ID# (Office use only.)

Student's Address (include city): | Zip Code:

Student's Date of Birth: | Age: | Religion: | Race: | Ethnicity:

Birth Sex: ☐ Male ☐ Female

Student's Social Security Number: | School: | Student's Grade:

Preferred Language: | **Student's Email:** | **Student's Cell Phone:** ( )

Name of Mother (include maiden name) or Legal Guardian: | Next of kin? ☐ Yes ☐ No | **Home Phone:** ( ) | **Work Phone:** ( ) | **Cell Phone:** ( ) | Employer:

Name of Father or Legal Guardian: | **Home Phone:** ( ) | **Work Phone:** ( ) | **Cell Phone:** ( ) | Employer:

**Parent's E-mail:**

Emergency Contact: | Relationship: | Phone: ( )

Emergency Contact: | Relationship: | Phone: ( )

Student's Primary Care Physician: | Phone: ( )

Student's Dentist: | Phone: ( )

Preferred Pharmacy: | Names of siblings enrolled in School Based Health Center:

Please check the type of health insurance your child has:

**Please send a copy of insurance card (front and back) to SBHC.**

☐ Medicaid/Healthy Louisiana #: ______________________________ (check one below)
☐ Amerigroup of LA ☐ AmeriHealth Caritas LA ☐ Aetna Better Health
☐ LA Healthcare Connections ☐ United Healthcare Community Plan
☐ Medicaid (dental) #: ______________________________
☐ No insurance
☐ Private/Other Insurance Co. Name:______________________________________________
Co. Address:________________________________________ Phone #:_________________
Policy #:________________________ Group#:__________ Effective Date:________________
Name of policy holder:______________________ Relationship to student:________________
Policy holder date of birth:___________ Policy holder Social Security #:_________________
Does your insurance pay for prescriptions? ☐ No ☐ Yes

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

Is your child allergic to any food or medicine? ☐ No ☐ Yes If yes, list:

List of current medications student is on with dosage (how much) and how often:

***All services are provided by licensed professionals***

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.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Innis Community Health Center, Inc at 225-492-3775.

**BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:**

- Primary and preventive health care
- comprehensive history and physical examinations
- immunizations
- health screenings
- laboratory/diagnostic testing
- acute care for minor illness and injury
- Administration of over the counter medication as needed
- management of chronic diseases
- behavioral health services
- health education and prevention programs
- case management
- referral and follow-up for emergencies
- referral to specialty care
- Telehealth
- Teledentistry
- dental services (where available)
- fluoride varnish
- transportation to SBHC site at Brusly Middle School

I hereby assign all payments of benefits for Medical/Dental Services rendered to Myself or dependents under the above plan to Innis Community Health. I understand that I am financially responsible for any charges not covered by the assignment. I also hereby authorize release of information required in the course of these services as may be needed to process my Claims. Claims cannot be filed without your signature.

I hereby authorize or consent to the diagnostic and/or therapeutic treatment for myself or the minor named below that may be considered necessary or advisable by the professional healthcare providers of the clinic.

**By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.**

**This consent is effective while the student is enrolled in Brusly SBHC unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every school year to update important information.**

We also understand that the School-Based Health Center is operated by Innis Community Health Centers, Inc. and its employees and contractors.

| ________________________________ | ________________________________ |
|---|---|
| Printed Name of Parent/Legal Guardian | Relationship |
| Signature of Parent/Legal Guardian | Date |
| Signature of Student | Date |

This consent may be withdrawn or modified at any time with written permission 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.

Office use only: Reviewed/Entered by: Date:

Effective July 2022

**Office use only.**

**Student's Name: ________________________________ Date of Birth ________________________**

**Confidentiality:** The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Brusly School Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of Innis Community Health Centers, Inc. Notice of Privacy Practices that describes how my health information is used and shared. I understand that Brusly School Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 225-384-2668 or 225-344-0008. My signature below constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

We consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the school nurse and the health center staff as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal.

The school board and the school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than I) a healthcare provider (for diagnosis, treatment, or counseling purposes): (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate Consent given on the Attachment.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment. I have read and understand the information in this form. I give permission for my child to have medical treatment at the Brusly High School Based Health Center. I am the legal guardian of the child.

*I acknowledge receipt of the Notice of Privacy and understand I may call the Brusly SBHC at 225-385-2668 or 335-344-0008 to have any questions answered regarding The Notice of Privacy.*

**Signature:** ________________________________________ **Date:** ____________________

**Your Name (Please Print):** ________________________________________________

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STUDENT NAME: ______________________________________ DOB: ______________ GRADE: ________

**Student Medical History** *(Please indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

| Y | N | Medical Condition | Y | N | Medical Condition |
|---|---|---|---|---|---|
| | | Abnormal Bleeding | | | Ear Infections |
| | | ADHD/ADD | | | Hearing Loss |
| | | Allergies | | | Speech Problems |
| | | Asthma (Please bring inhaler to clinic) | | | Mental Health Concerns/Depression |
| | | Birth Defect | | | Physical Disability |
| | | Brain/Head Injury | | | Respiratory (Lung Problems) |
| | | Broken Bones | | | Rheumatic (Scarlet) Fever |
| | | Cardiovascular (Heart) Problems | | | Seizures |
| | | High Blood Pressure | | | Sickle Cell Disease |
| | | Dental Disease | | | Vision Problems/Eye Disorders |
| | | Diabetes | | | Staph Infection (Abscess or Boil) |
| | | Eating Problems/Poor appetite | | | COVID-19 |
| | | | | | Other: |

**Student Surgical & Hospitalization History**

**Has your child ever had surgery?** ***(If yes, please specify below)*** ☐ Yes ☐ No

| Y | N | Surgery | Y | N | Surgery |
|---|---|---|---|---|---|
| | | PE Tubes (Tubes in Ears) | | | Adenoidectomy |
| | | Appendectomy | | | Bone or Joint Surgery |
| | | Tonsillectomy | | | Other: |

**Has your child ever been admitted into a hospital?** ***(If yes, please specify below)*** ☐ Yes ☐ No

| Hospital | Date | Reason |
|---|---|---|
| | | |

**Family Medical History** *(Which of the following medical conditions apply to you or an immediate family member)*

| Y | N | Condition & Details | Relationship to Student (Mother, Sister, etc.) | Y | N | Condition & Details | Relationship to Student (Mother, Sister, etc.) |
|---|---|---|---|---|---|---|---|
| | | Asthma | | | | Diabetes | |
| | | Cancer | | | | Seizures | |
| | | High Blood Pressure | | | | Sudden death before age 50 | |
| | | Heart Disease/Heart Attack | | | | Sickle Cell | |
| | | Emotional/Mental Health Concerns | | | | Tuberculosis | |
| | | Nervous/Mental Disorder | | | | Other: | |
| | | Other: | | | | Other: | |

**Signature of Parent/Guardian** ______________________________________ **Date** _______________

**Contact Number** _____________________

# Request to Immunize

Patient Name:_______________________________________ Date of Birth____________________

We are pleased to assist you in keeping your child healthy by completing immunizations that will be due this school year. Signing this form indicates that you will receive the VIS forms prior to administering immunizations and you request the School-Based Health Center give your child CDC recommended vaccines including:

**Required Vaccines:**

HepA (Hepatitis A) Meningococcal
HepB (Hepatitis B) Varicella (chickenpox)
Tdap (Tetanus, diphtheris, acellar pertussis)
MMR (Measles, mumps, rubella)
Polio
DTaP (Diphtheria, tetanus & acellular pertussis)

**Optional Vaccines: Check Yes or No**

HPV (Human papillomavirus) **YES__NO__**
Influenza **YES___ NO____**

Please answer the questions below by circling "yes" or "no"

| | | |
|---|---|---|
| Has your child ever had the chickenpox disease? | Yes | No |
| Does your child have any allergies to medication, food or vaccine? | Yes | No |
| Has your child had a serious reaction to a vaccine in the past? | Yes | No |
| Has your child had a seizure or a brain problem? | Yes | No |
| Does your child have Cancer, Leukemia, AIDS or any other immune problem? | Yes | No |
| Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? | Yes | No |
| Has the student received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year? | Yes | No |
| Is your child pregnant or a chance she could become pregnant in the next month? | Yes | No |
| Has your child received vaccinations in the past 4 weeks? | Yes | No |
| Is your child allergic to eggs\chicken? | Yes | No |

What Doctors office did your child receive his/her childhood vaccines?______________________________

If you have any updated records at home, please send them to school with your child. We will make a copy and return your original.

If you would like the Brusly School Based Health Clinic to administer vaccines, please sign below. There is no cost to you for this service. Please call 225-385-2668 or 225-344-0008 if you have any questions or concerns.

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Student Name_______________________________________________ Date of Birth__________________________

I, (PARENT/GUARDIAN NAME) ____________________________________give permission for my child to receive immunizations at the Brusly School Based Health Clinic. Please sign below as receipt of Vaccine Information Statements.

________________________________________ ________________________________________

**PARENT/GUARDIAN SIGNATURE** **DATE**

# ALL PATIENTS

## Private Insurance & Uninsured

ATTENTION: You may be eligible for discounted services, even with private insurance. With High deductible health plans and large co-pays, we offer discounted services to ALL who qualify. Please Complete the form below to determine eligibility. Your discount savings are applied to your portion of payments (deductibles and co-pays).

**I decline to apply for discounted services**

______________________________
**signature**

**Number of Household** # ____________

**Annual Household Salary** $ ____________

○ **No, Not Qualified**
○ **Yes, Qualified**

***Once qualified, You must bring valid proof of income in to receive your discounts. Proof of income accepted: Tax Return, Recent Check Stub, Bank Statement, Social Security Letter, Food Stamp Award Letter. Your discount is valid for one year.***

**% Percent Discount**

| Persons in family/household | Discounts are determined by the below payment system | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2022 Discount Guidelines | | | | | | | | | |
| | Minimum Fee (20.00) | | 25% Pay | | 50% Pay | | 75% Pay | | 100% Pay | |
| **Family Size** | **0% From** | **100% To** | **101% From** | **133% To** | **134% From** | **166% To** | **167% From** | **200% To** | **200% From** | **Over To** |
| **1** | $ - | $13,590.00 | $ 13,591.00 | $ 18,754.20 | $ 18,755.20 | $ 20,385.00 | $ 20,386.00 | $ 23,782.50 | $ 23,783.50 | $ 27,180.00 |
| **2** | $ - | $18,310.00 | $ 18,311.00 | $ 22,887.50 | $ 22,888.50 | $ 27,465.00 | $ 27,466.00 | $ 32,042.50 | $ 32,043.50 | $ 36,620.00 |
| **3** | $ - | $23,030.00 | $ 23,031.00 | $ 28,787.50 | $ 28,788.50 | $ 34,545.00 | $ 34,546.00 | $ 40,302.50 | $ 40,303.50 | $ 46,060.00 |
| **4** | $ - | $27,750.00 | $ 27,751.00 | $ 34,687.50 | $ 34,688.50 | $ 41,625.00 | $ 41,626.00 | $ 48,562.50 | $ 48,563.50 | $ 55,500.00 |
| **5** | $ - | $32,470.00 | $ 32,471.00 | $ 40,587.50 | $ 40,588.50 | $ 48,705.00 | $ 48,706.00 | $ 56,822.50 | $ 56,823.50 | $ 64,940.00 |
| **6** | $ - | $37,190.00 | $ 37,191.00 | $ 46,487.50 | $ 46,488.50 | $ 55,785.00 | $ 55,786.00 | $ 65,082.50 | $ 65,083.50 | $ 74,380.00 |
| **7** | $ - | $41,910.00 | $ 41,911.00 | $ 52,387.50 | $ 52,388.50 | $ 62,865.00 | $ 62,866.00 | $ 73,342.50 | $ 73,343.50 | $ 83,820.00 |
| **8** | $ - | $46,630.00 | $ 46,631.00 | $ 58,287.50 | $ 58,288.50 | $ 69,945.00 | $ 69,946.00 | $ 81,602.50 | $ 81,603.50 | $ 93,260.00 |
| **Based on 2022 Poverty Guidelines, US Dept. Health & Human Services** | | | | | | | | | | |

http://aspe.hhs.gov/poverty-guidelines