Greater Lawrence Family Health Center

SCHOOL BASED HEALTH CENTER

☐ **Greater Lawrence Technical School**

☐ **Lawrence High School**

Patient Name: _____

Patient DOB: _____

MR#: _____

Patient Consent Form

INFORMED CONSENT FORM FOR TREATMENT AND OTHER PREVENTIVE HEALTH CARE SERVICES

- Evaluation, diagnosis and treatment of minor or acute illness and injuries.
- General health assessments and examinations.
- Standard immunizations.
- Laboratory and screening tests for minor and acute illnesses.
- Well child care if not currently under care of M.D.
- Health and human sexuality education and counseling.
- Diet/Nutrition education and counseling
- Behavioral Health Counseling
- Information and referral to other health and social service agencies in the community as needed

Please read and complete the consent form below so that your child may receive services at school.

I give my consent for my child to receive medical and behavioral health care at the Greater Lawrence Family Health Center's School Based Health Center. I give permission for the School Staff to refer my child to the Center to receive medical care. I authorize a physician or designated health professional to provide necessary treatment for my child and to share information with other health providers as appropriate. I give my permission for Greater Lawrence Family Health Center staff to have access to my child's student health records and school schedule as needed. I give my permission for necessary medical tests, procedures, and treatments in the medical evaluation and management of my child's medical care. I have completely disclosed below all known allergies, chronic illnesses, prior medication or drugs which have resulted in adverse reactions, and current medications with respect to my child.

I understand the Massachusetts Law, c. 112, s. 12F permits the student to be treated in an emergency and gives minors the right to consent on their own to confidential diagnosis and treatment if they have been exposed to certain diseases, such as sexually transmitted diseases; are pregnant; or support themselves and live on their own. Minors may also be able to consent to treatment for substance abuse and mental health problems. I also understand that the Center may have policies which encourage a minor's involvement in decisions about treatment and sharing information. I understand that my child may be offered a private patient portal account to communicate with Greater Lawrence Family Health Center clinicians.

This consent shall remain in effect for the duration of my child's tenure at the school selected above. I understand that I may revoke this consent at any time by submitting written notice to the GLFHC School Based Health Center.

CHILD'S NAME: _____ DATE OF BIRTH: _____

ALLERIGES (If Any): _____

MEDICAL ILLNESSES (Past and Present) DATE OF ONSET

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS (If Any): _____

(TURN OVER)

PREVIOUS ADVERSE REACTIONS TO MEDICATION/DRUGS

REACTION(S) NOTED

_____ _____

_____ _____

REGULAR DOCTOR /OTHER HEALTH CARE PROVIDER:

NAME: _____ ADDRESS:_____

PHONE NUMBER: _____

Parents/guardians will be notified of conditions requiring extensive work-up or treatment. Laboratory tests, x-rays, other diagnostic tests, and medical consultant visits are the responsibility of the parent/guardian or their insurer. Authority is hereby granted to GLFHC to claim and collect medical insurance payments on my behalf. I authorize the release of all necessary information to insurance companies for verification of services rendered.

1. ___ PRIVATE MEDICAL/HEALTH INSURANCE

   INSURANCE NAME:_____POLICY NUMBER: _____

   CARD HOLDER'S NAME: _____

2. ___ MASSHEALTH
   CARD/CHILD'S POLICY NUMBER: _____

3. ___ NO MEDICAL/HEALTH INSURANCE

I have read and completed this consent for my child and have been offered a copy of GLFHC's Notice of Privacy Practices as required by HIPAA. I understand that any questions I have concerning this health service can be answered by calling 978-686-8521.

NAME OF PARENT/GUARDIAN (please print): _____

DATE OF BIRTH OF PARENT/GUARDIAN:_____/_____/_____

PARENT/GUARDIAN'S DAY TIME PHONE NUMBER(S): _____

PARENT'S SOCIAL SECURITY NUMBER: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____

CHILD'S NAME: _____

CHILD'S SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____

CITY:_____STATE:_____ZIP CODE: _____

SIGNATURE OF CHILD/PATIENT: _____

DATE: _____

RETURN TO: SCHOOL BASED HEALTH CENTER