Carevide

Date: _____ Chart #_____

School-Based Health Care

903.259.3602

School Name: _____ **Grade:** _____ ☐ **Current student** ☐ **Sibling of current student** ☐ **Staff child**

STUDENT INFORMTION

Student Name: *First:* *Last:*	Date of Birth:
Street:	Apt number:
City:	Zip code:
Gender: ☐ Male ☐ Female	Is the student homeless? ☐ Yes ☐ No
Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ Other ☐ I do not wish to report	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Is the student currently a patient of Carevide? ☐ Yes ☐ No	

PARENT INFORMAITON

1.Parent/Guardian Name:	Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
2.Parent/Guardian Name:	Date of Birth:	Phone:	Phone – Alternate:	Relationship to student:
Emergency Contact Name:		Phone:	Phone- Alternate:	Relationship to Student:
Parent/ Guardian email:				

INSURANCE

Does the student have insurance? ☐ Yes ☐ No Type of insurance: ☐ Medicaid ☐ CHIP ☐ Private Insurance Company / Medicaid Plan Name:	Family Size: _____ Gross Income: $_____ *(please circle)*wk./mo./yr. *Information will be used to determine the student's eligibility for Carevide's sliding fee discount program.*

Subscriber Name: _____

Insurance ID#: _____ Group ID#: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Claims Phone Number: _____

If student is uninsured, you may contact Carevide's Outreach staff for assistance with insurance enrollment services.

Student name: _____ **Date of Birth:** _____ **School:** _____

CONSENT FOR MEDICAL SERVICES

- I am the custodial parent or legal guardian of the minor child named above. I understand that I am not required to attend my child's medical appointment, but I may, if I choose to do so. I understand, if I am not present during my child's appointment, a representative from Carevide or CISD will contact me prior to, during, and/or after my child's visit.

- I authorize Carevide's nurse practitioner and/or physician to treat my child in my absence and if necessary, an authorized adult may accompany my child to receive medical services. The authorized adult may be a medical assistant, a school nurse, the school principal, a school administrative employee, or an adult named by one of them.

- I authorize and consent to my child receiving services from Carevide and its affiliated providers. Services may include, but are not limited to:

  - Any mandated school health services requested from Carevide.
  - Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new school admissions.
  - Medically prescribed laboratory tests.
  - Medical care and treatment, including diagnosis and treatment of acute and chronic illness, dispensing and prescribing of medications, contraceptive management, and diagnosis and treatment of STIs.
  - Behavioral health services including evaluation, diagnosis, treatment and referrals.
  - I understand that Carevide is required by state law to report information to the designated state health department when persons test positive for certain diseases (known as "reportable diseases") including, but not limited to, tuberculosis, HIV/AIDS, and syphilis.

Parent/Guardian Signature: _____ **Date:** _____

DISCLOSURES, RELEASES & AUTHORIZATIONS

- A clinical summary is provided to me following most visits. This summary may be in the form of a letter placed in my child's backpack or delivered through the mail, and/or through a phone call. I understand that some limited information, such as immunization history, may be provided by Carevide to the school and/or local or state health department(s).

- I authorize and direct Carevide to bill on my or my child's behalf and collect payment from any insurance or third-party payer that covers the services provided to my child. I understand I may receive a bill for any applicable co-payment, co-insurance, or sliding fee discount program amounts. If additional treatment is advised by Carevide providers, a referral will be provided to me at the address and/or phone number of record on this application form.

- I agree to the terms and information above. I am giving this consent of my own free will.

- I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Parent/Guardian Signature: _____ **Date:** _____