The Family Health Centers of Georgia, Inc.

SCHOOL-BASED HEALTH CENTER UPDATED CONSENT FORM

_____**School-Based Health Center** **Date:**____ _____

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order for your child to continue to receive services from the Health Center. It is your responsibility to notify us immediately of any changes in address, phone number or insurance.

PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name:_____
(first) (middle initial) (last)

Patient's Address:_____
(street)

City:_____ State:_____ Zip Code:_____

(Office Use Only) Address update _____

Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

(Office Use Only) Additional #'s Date/Name _____

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Patient's Social Security #:_____ Date of Birth:_____ Sex:_____

Birth Country: [ ] USA [ ] Other_____ Primary Language: [ ] English [ ] Other_____

School:_____

Grade:_____ Remedial/Special Education [ ] Yes [ ] No

Patient's Email:_____

INSURANCE INFORMATION

[ ] No Insurance [ ] Medicaid #:_____ [ ] Private Insurance

Please indicate insurance company's name for private insurance:_____

Member's Name (as listed on insurance card):_____ Policy #:_____

Group #_____ Address:_____

You may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? [ ] Yes [ ] No

UPDATED HEALTH INFORMATION

Any new **Medical Conditions (physical, behavioral health, dental):** [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Any new **Allergies (medications, food, environmental):** [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Dental Appointment in the past year: [ ] Yes [ ] No

I hereby give consent for my child to continue to receive medical, behavioral and dental services (when available) from _____ School-Based Health Center. I authorize any physicial-designated health professional, dentist or behavioral health provider workin for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

_____ _____

Name of Parent or Legal Guardian (please print) Name of Patient (please print)

X_____ _____

Signature of Parent or Legal Guardian Relationship to Patient

Date:_____

PATIENT DEMOGRAPHICS

Special Populations (Check all that apply.)

[ ] Migrant Agricultural Worker/Farmer
[ ] Public Housing (live in or access to)
[ ] Seasonal Agricultural Worker/Farmer
[ ] Veteran
[ ] None of the above
[ ] Choose not to disclose

Hosuing (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] Public Housing (live in or access to)
[ ] Shelter
[ ] Street (car, outdoors, makeshift housing)
[ ] Transitional Housing
[ ] None of the above
[ ] Choose not to disclose

SELF REPORTED INCOME

Number of people living in household: _____ Household Income: _____ [ ] Choose not to Disclose