Services Offered by PATHS School-Based Health At Your School via Mobile Unit

- Dental Exams
- Medical Care
- Prescriptions
- Labs
- Sports Physicals
- Immunizations
- Vision Care

NAME: _____ _____ _____

Student Date of Birth Grade

Gender Identity: ☐ **Male** ☐ **Female** Student School: _____

_____ _____ _____ _____

Mailing Address City State Zip Code

Lives with ☐ Father ☐ Mother ☐ Both ☐ Other: _____ Do you live in public housing? ☐ Yes ☐ No ☐ Homeless

Are you a Student? ☐ **Yes** ☐ **No** Are you a veteran? ☐ Yes ☐ No How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In person

Race (**check all that apply**):☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Japanese ☐DECLINE

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ DECLINED to specify **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____ **Interpreter Needed**: ☐ Yes ☐ No

Accessibility Needs: ☐ Hearing Impaired ☐ Vision Impaired

PARENTS/LEGAL GUARDIANS

Parent or Legal Guardian Name | Phone# (Home or Cell) | Phone # (Work) | Email Address

Parent or Legal Guardian Name | Phone# (Home or Cell) | Phone # (Work) | Email Address

RESPONSIBLE PARTY (REQUIRED)

Name_____ Phone#_____

Relationship to patient: _____ Birthdate: _____ SS#_____

_____ _____ _____ _____

Address City State Zip

Is this person also a patient enrolled in other PATHS services? ☐ Yes ☐ No

INSURANCE INFORMATION

Please **check all** that apply and send in a copy of the insurance card(s)

☐ **HEALTH INSURANCE** (Private insurance, Medicaid, ID Number/Policy Number, etc.) ☐ **NO HEALTH INSURANCE**

Name of Insured: _____ Relationship to Patient_____ Birthday: _____

PRIMARY Insurance Company ID/Policy Number Group Number

Do you have prescription coverage? ☐ **Yes** ☐ **No**

Name of Insured: _____ Relationship to Patient_____ Birthday: _____

SECONDARY Insurance Company ID/Policy Number Group Number

Do you have prescription coverage? ☐ **Yes** ☐ **No**

HEALTH INFORMATION

Doctor's Name_____ Current Medications _____

Please place an X for the following services you would like for your child to have during the current school year in the School-Based Health Center:

☐ **Medical Care** ☐ **Sports Physicals** ☐ **Immunizations** ☐ **Labs** ☐ **Prescriptions** ☐ **Dental Exams** ☐ **Vision Care**

EMERGENCY CONTACT

_____ _____

Name Relationship

_____ _____ _____ _____

Address City State Zip

(___)_____ (___)_____ (___)_____

Phone: Home Phone: Cell Phone: Work

I authorize PATHS School-Based Health to leave messages related to my care on my answering machine/voicemail ☐ **Yes** ☐ **No**

NOTICE OF PRIVACY PRACTICE/PARENTAL CONSENT

PATHS School-Based Health Notice of Privacy Practices are posted in the School-Based Health Center. Also, I may obtain a Notice of Privacy Practice by contacting the School-Based Health Center at (434) 791-0216. The Notice of Privacy Practice describes the types of uses and disclosures of your child's protective health information that might occur for their treatment, payment of their bills, or in the performance of PATHS School-Based Health Center operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your child's protected health information. I understand that PATHS School-Based Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the PATHS School-Based Health Center and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I, the parent/guardian of said student, give consent for him/her to receive health services. I understand those services may include nursing care, medical treatment, and referral for counseling; and that all healthcare information is confidential. I certify that I have been informed of the policies and procedures related to how PATHS School-Based Health Center, a division of Piedmont Access to Health Services, Inc., may use and /or disclose your child's personal health information.

By signing this consent form:

(1) I am authorizing my child to receive services in my absence;
(2) I am agreeing to accept the risks of medical procedures, medication(s), testing (including HIV), and other treatments;
(3) I am agreeing to abide by the PATHS procedures and patient responsibilities set out in this form;
(4) I am granting PATHS permission to bill my child's insurance for services provided.

I acknowledge that I have read this form or had this form read and explained to me, that I understand it and agree to its content. I agree to be truthful in providing information.

_____

Signature of Parent/Guardian **Date**

Revised 3/26/24

PATHS
Live Life. Be Healthy.