4OLA SCHOOL-BASED CLINIC CONSENT FOR TREATMENT

MINOR CHILD REGISTRATION FORM

By completing this form, I consent in advance to my child having access to any and/or all services available provided by 4OLA, Health Solutions, LLC as long as my child remains enrolled in Beaufort-Jasper EOC Head Start. Services include: diagnosis and treatment of common illness and injuries, laboratory testing, preventative health screening, health education mental health services and referrals as needed.

Student must have permission to be seen by 4OLA providers.

Student's Name (First, Middle, Last): _____

DOB: _____ SSN: _____ Gender: M F

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _____ Parents Email: _____

Mother/Guardian:_____ SSN: _____ DOB: _____ Phone: _____

Father/Guardian:_____ SSN: _____ DOB: _____ Phone: _____

Who does this child live with most of the time? _____

In Case of Emergency, please list two contact who may have access to student health information.

Name: _____Relationship: _____ Phone: _____

Does this patient have insurance? Y N

Primary Insurance

Name of Insurance Company: _____ Co-Pay Amount (if any)_____

Insurance ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: _____

Secondary Insurance

Name of Insurance Company: _____Co-Pay Amount (if any): _____

Insurance ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: _____

Primary Care Physician: _____

Pharmacy: _____ Pharmacy Location: _____

MINOR CHILD REGISTRATION FORM – PAGE 2

HIPPA/FERPA: All students have health issues that must be handled in a confidential manner. 4OLA staff will share information only in the following situations:

- When it is educationally relevant for a student's academic progress.
- When necessary to address a student's potential health care needs.
- To ensure the safety f the student, other students and school personnel.

For example, 4OLA staff may discuss the student's medication and other health care needs with the appropriate staff member who will administer the student's medication and provide care to the student in school.

Additional detailed information about the Privacy Policies that govern the 4OLA Telemedicine will be made available to the school nurse office.

I, the undersigned:

- Give permission and consent for my child to have treatment through and by 4OLA. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- Give permission for 4OLA to receive information from the school about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (also available in the office of the school nurse).
- Agree to release all records related to this treatment to the Primary Care Provider.
- Agree that I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All cost and fees not covered by insurance will be my responsibility.

As parent/guardian of the above student, I:

- Authorize the release of any information necessary to process insurance claims for payment of benefits to 4OLA, LLC
- Authorize payment of benefits to 4OLA, LLC for services rendered
- Have provided details of all insurance policies that cover my child

I received a copy of a "Notice of Privacy Practices" from providers who are authorized by my child's school district and/or a copy of the 4OLA "Notice of Privacy Practices".

Parent/Guardian Name (Print) _____

Parent/Guardian Signature: _____

Date: _____