PATIENT INFORMATION

Patient's First Name: ____________________ Middle Name: _______________ Last Name: ______________________

Date of Birth: ____________________________ month / day/ year Sex: ____ Male ____ Female

School: ____ Grade: ___________________________

Ethnicity: __Hispanic __ Black __ White __ American Indian __ Asian/Pacific Islander __ Other

Patient's cell phone: _______________Patient's email address: _________________________*(primarily for telehealth)*

Patient Address: ____
Street Address City State Zip Code

Who is the patient's regular doctor?
Name: ____ Telephone: ___________________________________
Address: ____

Which pharmacy do you prefer? CVS on 61st, Walgreens on 61st, Walgreens on 3rd/Seawall, CVS at Target, Kroger, Randalls, Walmart, Broadway Drug, Other ____

EMERGENCY CONTACT INFORMATION

Parent/Guardian First Name: ________________________ Parent/Guardian Last Name:_________________________
Parent/Guardian First Name: ________________________ Parent/Guardian Last Name: _________________________
Legal Guardian (If Applicable) Relationship to patient: __ Grandparent __ Aunt or Uncle __ Other: ________________
Parent/Guardian Preferred Language: ____

Contact Information for Parent/Guardian (*Important! Please provide as much contact information as possible so we will be able to contact you about your child's health.*):
Telephone Home: _______________________ Work: _______________________ Cell: _________________________
Email address: ____

Additional Emergency Contact Name: __________________________Relationship to Student:______________________
Telephone Home: _______________________ Work: _______________________ Cell: _________________________

INSURANCE INFORMATION

Does your child have Medicaid?
__ No __ Yes: Medicaid ID # _________________________

Does your child have Child Health Insurance Plan?
__ No __ Yes: CHIP # ______________________________

Does your child have other insurance?
__ No __ Yes: Name ______________________
Coverage Number: ________________________

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PATIENT MEDICAL HISTORY

Does your child have any allergies to medicine?
__ No __ Yes If yes, please describe:
Please list all medications your child receives: ____
____

Does your child have allergies, sensitivities, or reactions to any substances such as food, mold, pollen, animal dander, dust or insects?	No	Yes
Does your child have asthma?	No	Yes
Has your child ever had a seizure?	No	Yes
Does your child have diabetes?	No	Yes
Does your child have any known heart condition?	No	Yes
Has your child ever had to stay overnight in the hospital?	No	Yes
Has your child ever had surgery?	No	Yes
Has your child suffered from any trauma or severe injury?	No	Yes
Has your child had any mental health issues?	No	Yes
Does your child have any other health problems?	No	Yes

Please explain any "yes" responses: ____
____

FAMILY HEALTH AND SOCIAL HISTORY

Has any family member had heart disease before age 50?	No	Yes
Does any family member have Tuberculosis (TB)?	No	Yes
Have there been any mental health issues in the family?	No	Yes
Does any family member smoke tobacco in the home?	No	Yes

Please explain any "yes" responses:____
____

AUTHORIZATION FOR SPECIFIC HEALTH CARE SERVICES

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive services such as: routine physical examinations, weight/fitness program, TB skin test, immunizations, management of minor illnesses and injuries - including laboratory tests and medications, and general health education.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive counseling for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive medications for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals. Parent must be present for child to receive medications.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive reproductive services including family planning, birth control, and condoms.

- My child (Please CIRCLE one) **MAY** or **MAY NOT** receive counseling and testing for the HIV/AIDS virus.

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PARENTAL PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed above. I have the legal authority to consent for medical and mental health care for my child. My signature provides permission for my child to receive the services I have circled above from the Teen Health Center. I give permission for Teen Health to contact my child directly to set up appointments.

Delivery of Services
I understand that depending on the circumstances, my child's health care provider may choose to deliver services through face-to-face visits or telehealth visits. If services are delivered through telehealth, my health care provider will explain the benefits and risks to me.

Confidentiality
I understand that confidentiality between the patient and the health provider will be ensured in accordance with the law, and that patients will be encouraged to involve their parents or guardians in medical decisions and counseling. Teen Health Center works collaboratively with teaching hospitals and Universities. There may be times when learners (e.g., medical students, residents, graduate students) participate in patient care. The same HIPAA policies apply to these learners and confidentiality will be maintained. State law gives Teen Health the right to deny health records requests if our providers believe that release of records would be harmful to the patient's physical, mental, or emotional health. Also, minors have legal, exclusive rights to certain records (e.g. treatment/test results for reportable communicable diseases).

Sharing of Information
In the event of an emergency, I realize it may be necessary for the Teen Health Center, Inc to release my child's health information to the school district where my child's clinic is housed (Galveston Independent School District). This sharing of information is needed to protect my child's health and safety. I also realize that the Teen Health Center may share information with the school nurse to ensure that my child's vaccines are up to date. Separate authorization is required for sharing additional health information. I understand this information will remain confidential in accordance with federal and state laws. Teen Health's Notice of Privacy Practices will be given to patients at their first appointment, is available any time upon request, is publicly posted in all clinics, and is available for download at www.teenhealthcenter.org. My signature below indicates that I am aware that my child's health information may be released as indicated above and I have been given the opportunity to review the Notice of Privacy Practices.

Revocation of Consent
I understand that I can change my mind later and decide I do not want my child to receive services from the Teen Health Center. If I change my mind, I will let the Teen Health Center know in writing. I understand that this permission form remains valid until the Teen Health Center receives a written revocation from me. By law, parental consent is not required for urgent/emergent first aid treatment and the provision of services where the health of the patient appears to be endangered. Also, parental permission is not required for patients who are 18 years or older or for patients who are legally emancipated.

X ____ ______________
Signature of Parent/Legal Guardian Date

☐ Check box if you do not want to receive information via email or mail from the Teen Health Center, Inc.

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