Clarke County School District
Better Together

The Clarke Middle Health Center
Information, Authorization, and Consent for Health Services and Treatment

In order for your child to receive services at the Clarke Middle Health Center, this consent form must be completed and intake information obtained. Please complete all portions of this form.

I hereby voluntarily give my consent for _____ to receive services at The Clarke Middle Health Center (CMHC) I further authorize any clinic physician, health professional, clinic faculty or faculty-designated professional student working for the clinic to provide such screenings, medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical and behavioral health evaluation and management of my child's health care. Services provided by the health center may include, but are not limited to: management of acute and chronic illnesses, well-child checks, sports physicals, mental health counseling, and referrals to sub-specialists or other service providers.

- I authorize the release of information from my child's medical record to the primary care physician or primary care provider designated by me whenever necessary for their care including referrals and/or emergency services.
- I authorize the release of information from my child's medical record to the school nurse and from the school nurse to the school-based health center whenever necessary to coordinate their health care. Case records and intake survey information may be used for program evaluation in accordance with federal and state laws regarding patient confidentiality.
- I authorize the health center to release information regarding treatment for reasons in accordance with acceptable medical practice pursuant to the law. Physician and other Clarke Middle Health Center services are free of charge. ● I understand that my signing this consent allows the physicians, clinic staff, and trainees of the Clarke Middle Health Center to provide comprehensive health services. I understand that this consent is valid for the duration of my child's enrollment in the Clarke County School District. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.
- I acknowledge that the Clarke Middle Health Center has provided me with its Notice of Privacy Practices, which explains how my health information will be handled in various situations; and Clients Rights and Responsibilities, which I agree to abide by.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to the policies and procedures outlined above, and authorize services for your child's care as described. I also understand that I may obtain further information regarding the health services offered by the CMHC by contacting cmhc@clarke.k12.ga.us or 706-208-1190.

_____ _____ Name of

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

_____ _____ Signature

of Parent or Legal Guardian, Relationship to Patient Date

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

PATIENT DEMOGRAPHIC INFORMATION

Date: _____ Patient's Name: _____ _____ ___

Last First MI

Birth Date_____ Primary Language: ____ English ____ Other:_____

Sex as assigned at birth (circle one): Male Female Gender Identity:_____ Preferred Pronouns:_____ Race:

American Indian/Alaskan Native___Asian__Black/African American___Native Hawaiian/Pacific Islander___White___

Ethnicity: Hispanic/LatinX ___not Hispanic/LatinX___ Other: specify_____ School:

_____ Grade: _____

Address_____Apt.#_____ City_____State____Zip_____

(Office Use Only) Address/Phone update_____

Parent/Guardian Home Phone#: _____ Parent/Guardian Work Phone#: _____

Parent/Guardian Email: _____Child's Phone Number (if applicable): _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

Who lives with student: Please list everyone who lives in home including yourself:

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HEALTH INSURANCE AND FINANCIAL INFORMATION

***all patients are eligible for free services at the CMHC regardless of income, documentation or insurance status.**

Do you have any insurance that covers? ____ Health ____ Vision ____ Dental ____ No Insurance
If you have insurance, what services/specialty does your insurance exclude? _____.

Do you currently have Georgia Medicaid? ___ Yes ___ No Medicare Part B? ___ Yes ___ No I am: ___ Uninsured (no insurance) ___

Underinsured (do not have coverage for services being sought) Please provide the number of dependents in your household (include

self/spouse) _____.

Please provide gross family **MONTHLY income** from all sources: $ _____.

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PATIENT'S MEDICAL HISTORY

NAME_____ **DATE OF BIRTH**_____

Please list any current concerns:

_____

Please list the patient's current health problems that are under treatment:

_____

Please list all medications that patient takes (prescribed, over-the-counter, vitamins/supplements):

_____

Does the patient have any allergies to medications? ___Yes___No. If yes, please list medication and reaction:

_____

Please list any other allergies the patient has: _____

ILLNESS HISTORY

Allergies __ Yes __ No
Anemia __ Yes ___ No
Asthma __ Yes ___ No
Abdominal Pain __ Yes ___ No
Constipation/Diarrhea __ Yes ___ No
Reflux __ Yes ___ No
Ear/Hearing Problems __ Yes ___ No
Hearing Aid __ Yes ___ No
Eye Problem __ Yes ___ No
Glasses/Contacts __ Yes ___ No
Dental Problems __ Yes ___ No
Passed Out __ Yes ___ No
Headaches __ Yes ___ No
Heart Murmur __ Yes ___ No Heart Problems __ Yes ___ No High Blood Pressure __ Yes ___ No
Thyroid Problems __ Yes ___ No
Diabetes __ Yes ___ No
Injuries (major) __ Yes ___ No
Muscle/Bone Problems __ Yes ___ No
Broken Bones __ Yes ___ No
Problems Walking __ Yes ___ No
Kidney/Urine Problems __ Yes __ No
Frequent Sore Throat __ Yes ___ No
Frequent Colds __ Yes ___ No
Lung Problems __ Yes ___ No
Meningitis __ Yes ___ No
Hepatitis __ Yes ___ No
Tuberculosis __ Yes ___ No
HIV/AIDS __ Yes ___ No
Chicken Pox __ Yes ___ No, Age: ___
COVID-19 infection __Yes ___No
Menses Started __ Yes __ No, Age: __
Menstrual Problems __ Yes ___ No
Pregnancy __ Yes ___ No
Rheumatic Fever __ Yes ___ No
Low Birth Weight __ Yes ___ No
Weight Concerns __ Yes ___ No
Skin Rashes __ Yes ___ No
Serious Acne __ Yes ___ No
Hemophilia __ Yes ___ No
Sickle Cell Disease __ Yes ___ No
Sickle Cell Trait __ Yes ___ No Other Blood Disorders __ Yes ___ No
Seizures/Epilepsy __ Yes ___ No
Speech Problems __ Yes ___ No
Cancer __ Yes ___ No
Other_____

BEHAVIORAL HEALTH

Eating Problems __ Yes ___ No
Nightmares __ Yes ___ No
Bedwetting __ Yes ___ No
Discipline Problems __ Yes ___ No
Overactive/Hyperactive __ Yes ___No
Sleeping Problems __ Yes ___ No
Slow Development __ Yes ___ No
Learning Disability __ Yes ___ No
Alcohol or Drug Use __ Yes ___ No
Depression __ Yes ___ No
Anxiety __ Yes ___ No
Trauma __ Yes ___ No
Physical/Sexual Abuse __ Yes ___ No
Family Relationship Concerns __ Yes __ No
Peer Relationship Concerns __ Yes __ No
Other Behavior Problems __ Yes __ No
Other Mental Problems __ Yes ___No

Please explain any questions marked yes:

_____
_____
_____
_____
_____

Family History: (Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A,Uncle-U) Please specify who **has** or **had** any disease listed below by using abbreviations above.

Allergies _____
Asthma _____
Cystic Fibrosis _____
Lung Diseases _____
Tuberculosis _____
Ear/Eye Disorders _____
Heart Trouble _____ High Blood Pressure _____
Kidney/Bladder Problems _____
Blood Disorders/Anemia _____
Cancer _____
Seizures _____
Intellectual Disability _____
Diabetes _____
Muscle Disease/Weakness _____
Mental Illness ____
Substance Use Disorder____
Birth Defects _____
Early Childhood Death _____
Sudden or Unexplained Death Under Age 50 _____
Were any of these heart related? ___ Yes ___ No

None of the above _____

HEALTH ACCESS HISTORY

Where does your child go for Primary care/Routine care?_____

Where does your child go for Acute care/Emergency/Sick visits? _____

Primary Care Doctor: _____

Urgent/Emergency Care: _____

Is your child seeing any specialists? If yes, please list: _____

Pharmacy/Phone #_____

Would you like the CMHC to serve as your child's regular doctor? _____ Yes _____ No

During the past 12 months, did your child receive a well-child check when they were not sick or injured? ____ Yes ___ No Has your child seen a doctor for other reasons than a well-child check visit in the last year? ___Yes ____No If yes, how many times? (Circle)

1 time 2 times 3 times 4 or more times

Where?_____

Why?_____

Has your child used a hospital Emergency Room in the last year?____Yes ____No

If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times

Where?_____

Which of these apply to your child's last emergency room visit? (Please select all that apply):

	You didn't have another place to go
	Your doctor's office or clinic was not open
	Your health provider advised you to go
	The problem was too serious for the doctor's office or clinic
	Only a hospital could help you/your child
	The emergency room is your closest provider
	You get most of your care at the emergency room
	You arrived by ambulance or other emergency vehicle

Has your child ever spent the night in the hospital? ____Yes ____No

Where?_____

Why?_____ How Long_____

During the past 12 months, was there any time when your child needed dental care, but didn't get it? ____Yes _____No Child's

Regular Dentist_____Date of Last Visit_____

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BEHAVIORAL HEALTH

During the past 12 months, was there any time when your child needed mental health treatment or counseling, but didn't get it?
___ Yes___ No

If yes to the previous question please answer which of these statements explains why your child did not get the mental health treatment or counseling needed? Please select all that apply.

	You couldn't afford the cost.
	You were concerned that getting your child mental health treatment or counseling might cause your neighbors, community, or other family members to have a negative opinion of your child.
	You were concerned that getting your child mental health treatment/counseling might have a negative effect on your job.
	Your health insurance does not cover any mental health treatment or counseling.
	Your health insurance does not pay enough for mental health treatment or counseling.
	You did not know where to go to get services.
	You were concerned that the information you give the counselor regarding your child might not be kept confidential.

You were concerned that your child might be committed to a psychiatric hospital or might have to take medicine.

Some other reason(s) (please specify):

FOOD AND HOUSING INSTABILITY

In the past 12 months, was the child or anyone in the household ever hungry, but didn't eat because there wasn't enough money for food? ___ Yes___ No

"We couldn't afford to eat balanced meals." Was that often ___, sometimes____,or never true ____ for you in the last 12 months?

Has the child or the entire household moved three or more times in the last five years? ___Yes ___No Does the child or the entire household expect to move again soon? ___Yes ___No

Have you had your power or water shut off within the last 12 months? ___Yes ___No

LEGAL NEEDS

Does the child or a caregiver in the household have one or more legal needs that no one is currently helping with?
___Yes __No __Prefer not to Say

If "Yes", please indicate which of the following legal needs may apply (Please select all that may apply):

	Supplemental Nutrition Assistance Program (SNAP) Benefits (Application, Denial, Reduction, Program Violation, etc)
	Housing (Eviction, Discrimination, Unsafe Conditions, etc)
	Employment Conditions (Discrimination, Harassment, Unsafe Conditions, etc)

	Immigration Status (Citizenship, Visas, Asylum, Deferred Action, Deportation, Detention, etc)
	Family Law Matters (Guardianship, Adoption, Divorce, Custody, Interpersonal Violence, etc)
	Survivor of Serious Crime
	Other Criminal Matters
	Other Legal Issues