Montgomery Family Clinic
Dry Prong Family Clinic

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We are pleased to continue Montgomery Family Clinic and Dry Prong Family Clinic's partnership with Grant Parish Schools! Your child can be seen via telehealth by a licensed healthcare professional during school and without needing an appointment. In order for services to be rendered, a consent form must be signed.

The following billable services will be offered to your child:

- Primary and preventive health care
- Comprehensive history and physical examinations
- Immunizations
- Health Screenings
- Acute care for minor illness and injury
- Administering medications, if indicated
- Referral and Follow-Up
- Telehealth
- Behavioral Health Services and Risk Assessment
- Health Education and Prevention
- Dental Fluoride Treatment

Parents, please complete the school-based patient paperwork in this packet and return to your child's school. We look forward to serving your faculty, staff, and student's this school year and in the future!

800 Grove St.
Dry Prong, LA 71423
318.568.8298
318.568.8297

PO Box 37
Montgomery, LA 71454

641 Rowena St.
Montgomery, LA 71454
318.646.3000
318.646.3003

2024-2025 ENROLLMENT-CONSENT FORM
SCHOOL BASED HEALTH SERVICES

SCHOOL_____ GRADE_____ HOMEROOM TEACHER_____

PATIENT INFORMATION

FIRST NAME_____ MI_____ LAST NAME_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

MAILING ADDRESS ☐ check if same_____ CITY_____ STATE_____ZIP_____

DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY #_____

GENDER: ☐ Male ☐ Female ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

RACE: ☐ Asian ☐ White ☐ African American ☐ American Indian ☐ Alaska Native

GRANT PARISH SCHOOL BOARD EMPLOYEE? ☐ Yes ☐ No

NAME OF PRIMARY CARE PROVIDER_____ NAME OF CLINIC_____

Check if staff/student does not have a primary care provider: ☐

NAME OF DENTIST_____ NAME OF OFFICE_____

PREFERRED PHARMACY (NAME AND LOCATION)_____

PARENT OR LEGAL GUARDIAN INFORMATION

1. FATHER_____ DATE OF BIRTH_____ SSN_____

HOME PHONE _____ WORK PHONE _____ CELL _____

2. MOTHER_____ DATE OF BIRTH_____ SSN_____

HOME PHONE _____ WORK PHONE _____ CELL _____

3. GUARDIAN_____ DATE OF BIRTH_____ SSN_____

HOME PHONE _____ WORK PHONE _____ CELL _____

EMERGENCY CONTACTS

NAME_____ RELATIONSHIP_____ CELL_____

NAME_____ RELATIONSHIP_____ CELL_____

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No (PLEASE ATTACH COPY OF CARDS TO THE BACK OF PACKET)

1. Name of Primary Insurance_____ ID #_____

Policy Holder (if not the patient)_____ Policy Holder's DOB_____

2. Name of Secondary Insurance (if applicable)_____ ID #_____

Policy Holder (if not the patient) _____ Policy Holder's DOB_____

PERSONAL MEDICAL HISTORY

What have you been treated for in the past?

- ADD/ADHD
- AIDS/HIV
- ABUSE/DOMESTIC VIOLENCE
- ALLERGIES/HAYFEVER
- ANEMIA
- ANESTHESIA COMPLICATIONS
- ANXIETY
- ARTHRITIS
- ASTHMA
- AUTISM SPECTRUM DISORDER
- BEDWETTING
- BIRTH DEFECTS OR INHERITED DISEASES
- BLADDER OR KIDNEY PROBLEMS
- BLOOD DISEASES
- BLOOD TRANSFUSION
- BREAST CANCER
- BREAST PROBLEM
- COPD
- CANCER
- CHICKEN POX
- CHRONIC EAR INFECTIONS
- CONGESTIVE HEART FAILURE (CHF)
- CONSTIPATION
- CORONARY ARTERY DISEASE (CAD)
- DEPRESSION
- DEVELOPMENTAL OR BEHAVIORAL DISORDERS
- DIABETES
- DIFFICULTY SWALLOWING
- DIVERTICULITIS
- EAR OR HEARING PROBLEMS
- EATING DISORDERS
- ECZEMA
- ENDOMETRIOSIS
- FIBROMYALGIA
- GI PROBLEMS
- GOUT
- HEADACHES
- HEART DISEASE
- HEART PROBLEMS
- HEPATITIS
- HIGH CHOLESTEROL
- HOSPITALIZATIONS
- HYPERTENSION
- HYPERTHYROIDISM
- HYPOTHYROIDISM
- INFERTILITY
- KIDNEY DISEASE
- KIDNEY STONES
- LIVER DISEASE
- LUNG DISEASE
- MRSA EXPOSURE
- MENIERE'S DISEASE
- MENTAL DISORDER
- MENTAL ILLNESS
- MUSCLE, JOINT, OR BONE PROBLEMS
- OBESITY
- OSTEOPOROSIS
- OVARIAN CANCER
- POLYPS
- PRE-ECLAMPSIA
- PULMONARY EMBOLISM
- REFLUX/GERD
- SEIZURES/EPILEPSY
- SKIN PROBLEMS
- STROKE
- THROMBOPHILIAS
- THYROID PROBLEMS
- VARICOSITIES
- VISION/EYE PROBLEM
- OTHER_____

What specialty physicians do you CURRENTLY see? (Cardiology, ENT, pain management, pulmonology, etc.)

_____

Please list any recent hospitalizations. Include hospital(s) name/location, date(s) hospitalized and reason(s) for being hospitalized.

DOES STAFF/STUDENT HAVE ANY KNOWN ALLERGIES TO FOOD, MEDICATIONS, INSECTS, ETC.? ☐ YES ☐ NO

IF SO, PLEASE LIST: _____

_____

LIST ANY CURRENT MEDICATIONS THAT STAFF/STUDENT IS TAKING WITH DOSAGE (HOW MUCH) AND HOW OFTEN:

Name	Dose	Frequency

SURGICAL HISTORY

What surgeries have you had in the past? (include endoscopy studies – colonoscopy, upper GI study, and performing physician if known)

Procedure	Date (year, month if known)

FAMILY HISTORY

What has your family been diagnosed with?

Mother: ☐ Living ☐ Deceased (age of death) ____

_____

_____

Father: ☐ Living ☐ Deceased (age of death) ____

_____

_____

Siblings(s): ☐ Living ☐ Deceased (age of death) ____

_____

_____

Other significant family history (list relationship):

_____

_____

DENTAL FLUORIDE VARNISH TREATMENT CONSENT

Dental fluoride varnish treatments will be available for students as needed this school year. If you would like your child to receive treatment, please sign below.

Parent/Legal Guardian Signature: _____

WELLNESS IMMUNIZATION CONSENT

Wellness immunizations will be available for students this school year for those students with Medicaid. Wellness immunizations DO NOT include COVID-19 vaccines. Please sign below if you would like your child to receive his/her immunizations.

Parent/Legal Guardian Signature: _____

MEDICAL RELEASE OF INFORMATION

_____ I authorize the release of information including the diagnosis, records, (for example: lab results, medication/prescription information, pathology reports, etc.), examination rendered to me and claims information. This information may be released to:

_____ Spouse_____

_____ Child(ren)_____

_____ Parent(s)_____

_____ Other_____

_____I do not authorize this information to be released to anyone.

Signature: _____ Date: _____

This Release of Information will remain in effect until terminated by me in writing

HIPPA PRIVACY & RELEASE OF INFORMATION AUTHORIZATION

I, _____ hereby authorize Montgomery Family Clinic and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information release to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Montgomery Family Clinic. However, this authorization may not be revoked if; Montgomery Family Clinics' employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authorization.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am a legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

_____ _____

Patient/Guardian/Parent Printed Name Date

_____

Patient/Guardian/Parent Signature

By signing this consent form, you are agreeing to allow the Montgomery Family Clinic and Dry Prong Family Clinic to provide the following billable services to you (staff) or the student:

- Primary and preventative health care
- Comprehensive history and physical examinations
- Immunizations (Childhood wellness and flu, does not include COVID-19)
- Health Screenings
- Acute care for minor illnesses and injury
- Administering medications
- Referral and Follow Up
- Telehealth
- Health Education and Prevention
- Dental Fluoride Treatment
- Behavioral Health Services and Risk Assessment

Please list any services you would like to exclude your child from receiving from the above list:

- _____
- _____
- _____
- _____

By signing below, I (parent/guardian) acknowledge that I have read and understand the services to be provided at the school-based health center. I give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in the school unless the school is notified in writing that I no longer wish for my child to receive services.

We also understand the school-based health center is operated by Montgomery Family Clinic and Dry Prong Family Clinic and its employees and contractors.

_____ _____

Printed Name of Parent/Guardian Relationship

_____ _____

Signature of Parent/Guardian (or Staff) Date