SCHOOL-BASED HEALTH CENTER PATIENT CONSENT FORM
(School year 2020/2021)

The Family Health Centers of Georgia, Inc.

School District **Date:**_____

[ ] Clayton [ ] Douglas [ ] Fulton: College Park or Lake Forest (circle one)

You must complete all information **USING INK, SIGN & DATE** in order for your child to receive healthcare services from the Health Center. It is your responsibility to notify us immediately of any changes in address, phone number or insurance.

PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name:_____
(first) (middle initial) (last)

Patient's Address:_____
(street)

City:_____ State:_____ Zip Code:_____

[ ] Please check if address changed since 2019/2020 school year.

Patient's Social Security #:_____ Date of Birth:_____ Sex:_____

Birth Country: [ ] USA [ ] Other_____ Primary Language: [ ] English [ ] Other_____

School:_____

Grade:_____ Remedial/Special Education [ ] Yes [ ] No

Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Parent/Guardian'sEmail:_____

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact #: Home #:_____ Cell #:_____

Work #:_____ Other #:_____

INSURANCE INFORMATION

[ ] No Insurance [ ] Medicaid #:_____ [ ] Private Insurance

Please indicate insurance company's name for private insurance:_____

Member's Name (as listed on insurance card):_____ Policy #:_____

Group #_____ Address:_____

Your child may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? [ ] Yes [ ] No

HEALTH INFORMATION

Medical Conditions (physical, behavioral health, dental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Allergies (medications, food, environmental): [ ] Yes [ ] No

If yes, please list:_____ _____

_____ _____

_____ _____

Dental Appointment in the past year: [ ] Yes [ ] No

PATIENT DEMOGRAPHICS

Special Populations (Check all that apply.)

[ ] Migrant Agricultural Worker/Farmer
[ ] Public Housing (live in or access to)
[ ] Seasonal Agricultural Worker/Farmer
[ ] Veteran
[ ] None of the above
[ ] Choose not to disclose

Hosuing (Check all that apply.)

[ ] Doubled Up (temporarily living with others)
[ ] Homeless
[ ] Other (hotel, motel, other day to day payment, etc.)
[ ] Public Housing (live in or access to)
[ ] Shelter
[ ] Street (car, outdoors, makeshift housing)
[ ] Transitional Housing
[ ] None of the above
[ ] Choose not to disclose

SELF REPORTED INCOME

Number of people living in household: _____ Household Income: _____ [ ] Choose not to Disclose

I hereby give consent for my child to continue to receive medical, behavioral and dental services (when available) from The Family Health Centers of Georgia's School-Based Health Center. I authorize any physicial-designated health professional, dentist or behavioral health provider workin for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

_____ _____

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

X_____ _____

Signature of Parent or Legal Guardian Relationship to Patient

Date:_____