Outreach Consent Form

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) will be providing outreach services at your child's school this year. All children are invited to participate in CHC/SEK's outreach program. No child will be denied services based on insurance status or ability to pay. However, insurance, if available, will be billed. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please call **620-240-5061**. *Please complete this form in ink.*

School Name: ____

Student Name: _______________________________________**DOB**:__________**Grade**:_____ **Gender**: _______

Race:

- € American Indian or Alaskan Native
- € Asian
- € White
- € Black or African American
- € Native Hawaiian or Other Pacific Islander
- € Other Race

Ethnicity (circle one): Hispanic or Latino -OR- Not Hispanic or Latino

Do you want access to your medical records electronically? (circle one) YES OR NO

IF yes, Email Address: ____

(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL)

Does the child have medical insurance? (circle one) YES OR NO

If YES, complete the insurance section below. CHC/SEK will bill your insurance for services provided.

- € KanCare (Amerigroup, United Health Care, Sunflower) #_______________________________________
- € Medicaid (Oklahoma or Missouri)#____
- € Commercial/ Private Insurance

Subscriber Name_____________________________________DOB_____________SSN#____________________

Insurance Company______________________________Policy#_____________________Group#____________

Parent/Guardian Name__________________________________ Daytime Phone #________________________

Address_______________________________________City________________State________Zip__________

Consent: As parent or legal guardian of the child named above, I give Community Health Center of Southeast Kansas, Inc. permission to provide my child with medical outreach services by CHC/SEK healthcare professionals. This consent is valid for one (1) year from the Parent/ Guardian Signature date below.

Parent/Guardian Signature______________________________________ **Date**___________________________

Please complete and sign the Medical History Form on the other side

03/2019

Medical History Form

Student Name: ____ DOB_____________________________

Medical History: Please check all that apply

Heart Condition:	❑ Heart Murmur	❑ Congenital Heart Disorder	❑ Other: ________________________
Lung Condition:	❑ Asthma	❑ Cystic Fibrosis	❑ Other: ________________________
Endocrine Condition:	❑ Diabetes	❑ Thyroid Disorder	❑ Other: ________________________
Neurologic Condition:	❑ Seizure Disorder	❑ Concussion	❑ Other: ________________________
Bone/Joint Condition:	❑ Pins/Screws	❑ Rheumatoid Arthritis	❑ Other: ________________________
Infectious Condition:	❑ Hepatitis	❑ HIV	❑ Other: ________________________
Behavioral Health:	❑ Anxiety	❑ Depression	❑ Autism Spectrum
	❑ Other: ________________________		
Severe Allergy to:	❑ Peanuts	❑ Bee/wasp stings	❑ Other: ________________________
	Reaction: ________________________		

Other Condition(s): ____

Does your child have special health care needs? (circle one) YES OR NO

IF yes, please explain: ____

____

Surgeries/Hospitalizations? (circle one) YES OR NO

IF yes, please explain: ____

____

Please list any known allergies (medications, foods, etc.): ____

____

Please list all medications your child is currently taking (including over the counter medications): __________________

____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature____ **Date**______________________________