Louisiana Academic Health

PATIENT REGISTRATION

School Clinic Name:_____

School Term:_____

Last Name:_____ First Name:_____ MI:_____

Preferred Name:_____ DOB: _____ Sex:_____ Preferred Sex:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Address: _____ City:_____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Email:_____

Pharmacy Name: _____ Pharmacy Location & Phone # _____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone:_____

PRIMARY INSURANCE

Insurance Company Name:_____

Address: _____

City: _____ State_____ Zip _____

Phone #_____

Policy Holder Name: _____

Birth Date: _____Relationship_____

Policy # _____

Group # _____

SECONDARY INSURANCE

Insurance Company Name:_____

Address: _____

City: _____ State_____ Zip _____

Phone #_____

Policy Holder Name: _____

Birth Date: _____Relationship_____

Policy # _____

Group # _____

PATIENT MEDICAL HISTORY

Please list any medications or dietary supplements you are taking:

_____

_____

_____

Allergies

Allergy Type: ☐ Food (list foods)_____

☐ Insect sting (list insects)_____

Reactions: List date of last occurance if any.

☐ Coughing_____ ☐ Hives_____ ☐ Rash _____

☐ Difficulty breathing_____ ☐ Local swelling _____

☐ Wheezing_____ ☐ General swelling_____

☐ Nausea_____ ☐ Other_____

Current prescribed medications:

☐ Oral antihistamine ☐ Epi-pen ☐ Other:_____

List any assistive devices you are using (braces, crutches, shoe inserts):

_____

Have you completed advanced medical directives? (aka: "living will")

☐ Yes ☐ No

Do you have difficulties with? (check all that apply)

☐ Communication ☐ Vision ☐ None

☐ Speech ☐ Hearing

☐ **Asthma.** Please check off triggers:

☐ Environmental (tobacco, dust, pollen, etc.) ☐ Other:_____

Symptoms:_____

☐ **Seizure Disorder.** Please check type of seizure:

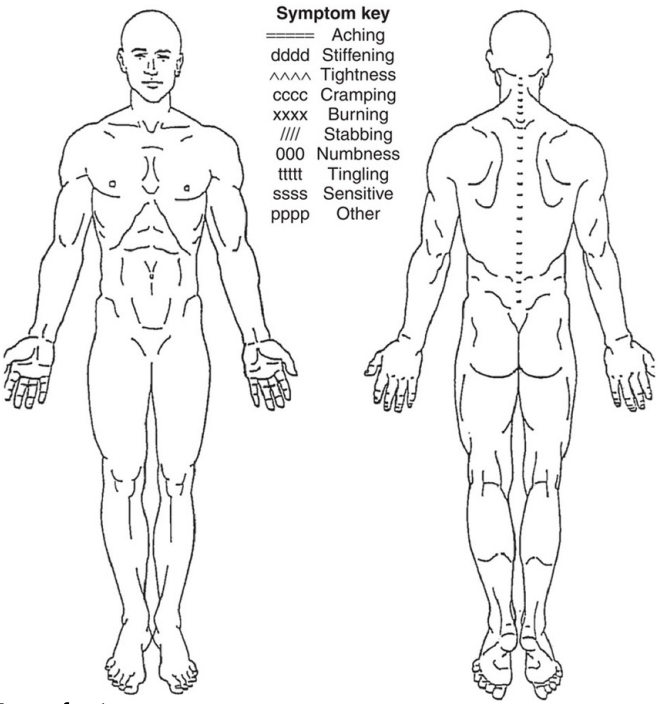
☐ Absence (staring, unresponsive) ☐ Complex Partial

☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)

☐ Physical Education Restrictions: ☐ Yes ☐ No

☐ Physical Disability (please explain)_____

Circle the location of pain on the chart and list the type below:



Type of pain:

_____

Rate your level of pain in the last 72 hours. Circle one.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain imaginable

Additional Comments:

_____

_____

Medical History	**Self**		**Family**	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Rheumatoid Arthitis?	Yes	No	Yes	No
Neurological dz (MS,Parkinsons)?	Yes	No	Yes	No
Ulcers/GERD/Acid Reflux?	Yes	No	Yes	No
Kidney/Liver Disease?	Yes	No	Yes	No
Prior Surgeries?	Yes	No	Yes	No
Other:_____	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

Changing in your general health?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight change (>10lbs)?	Yes	No
Numbness or tingling?	Yes	No
Bowel/bladder incontinence?	Yes	No
Difficulty sleeping due to pain?	Yes	No
Unexplained falls/decreased balance?	Yes	No

Are you currently/do you have:

Pregnant/Potentially Pregnant/Nursing?	Yes	No
Often bothered by feeling down, depressed or hopeless?	Yes	No
Often experience little interest or pleasure in doing things?	Yes	No
Under physical/emotional abuse?	Yes	No
Dietary or Nutritional Concerns?	Yes	No
Do you use tobacco products?	Yes	No
Do you drink alcoholic beverages?	Yes	No
Do you take illegal substances?	Yes	No

Consent to Treatment & Release of Information

By signing this enrollment and consent form, you consent to the following:

• I authorize LAHN/LAHN-CA to examine and treat my child at the School Clinic, and I understand that no guarantee has been made as to the results of such examinations and treatments.

• I authorize LAHN/LAHN-CA in conjunction with CA and any of its certificated staff to communicate and share information to assist LAHN/LAHN-CA to treat my child, including but not limited to my child's family and emergency contact information, attendance records and disciplinary information, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and any health conditions such as seizures or asthma.

• I authorize LAHN/LAHN-CA staff members to release any medical records required by the insurer or other payer to obtain payment. Following applicable legal requirements, LAHN/LAHN-CA staff members may use and share my child's medical information for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. A Notice of Privacy Practices document is available to me at the location my child receives his/her health care services and on the CA website.

• This Consent expires at the end of the school year or when my child leaves the school district, whichever is earlier.

Revocation
I understand that this Consent Form may be revoked in writing at any time and that the revocation will take effect on the day it is received by LAHN/LAHN-CA at the School Clinic. The revocation must be in writing and signed by my. The revocation will not be effective to the extent that Requestor or others have acted in reliance on this Consent For Medical and/or Behavioral Treatment.

Acknowledgment
I have carefully read the foregoing Consent for Medical and/or Behavioral Treatment and fully understand the meaning of this consent form. I affirm that I have signed this authorization voluntarily.

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this I also provide authorization to disclose pertinent information among medical, behavioral and social service staff in order to provide comprehensive care for my child.

Patient Signature_____ **Date**_____

Parent or Gaurdian Signature (if minor)_____ **Date**_____