AARON E. HENRY
COMMUNITY HEALTH SERVICES CENTER, INC.

MISSISSIPPI CHILDREN'S HEALTH PROJECT
PARENT/GUARDIAN CONSENT FORM

MEDICAL

GREAT HEALTH MAKES GREAT MINDS!!!

*****It's tough for a child to pay attention and do well in school if he/she isn't healthy.**

To help you care for your child, this partnership is pleased to offer screenings, annual physicals, eye exams and dental services to all school aged children regardless of insurance coverage. There is **NO Out-of-Pocket COST** to the parent/guardian. Insurance will be billed or services offered at no cost for those without insurance. There are no co-pays/deductibles and no bill will be sent home.

No long wait times at a medical office.
****No need to miss school or work for medical reasons.***
*****Access to a healthcare provider for education and questions.***

A fully equipped mobile unit with private exam rooms will come to each school to perform comprehensive physicals, eye exams and dental services. Services may include complete, unclothed physical examinations, dental varnishing, as well as necessary laboratory tests, immunizations, and treatment of identified health problems.

CHILD's INFORMATION

The information you provide will serve as your written permission for AEH to provide health services for your child.

Child's Name_____ Child's Birth Date: _____/_____/_____

Gender: Male _____ Female _____ Special Accommodations Required? _____

Name of School _____ Grade _____ Race/Ethnicity_____

Child's Home Address: _____ City/State_____

Child's/Parent's Mailing Address: (***If different from home address***) _____

Child's Social Security #: _____ Medicaid/CHIP #: _____

Parent/Guardian (***Print***) _____ Social Security #: _____

Relationship to child _____ Home Telephone #: _____

Parent/Legal Guardian's Emergency or Work Telephone # (***very important***) _____

Parent/Legal Guardian's Email Address: _____

Other Insurance _____ Policy # _____

Insurance Group # _____ Insured's Name _____

Insured's Date of Birth _____/_____/_____ Insured's SS # _____

Physician's Name _____ Date of Last Visit: _____

Dentist's Name _____ Date of Last Visit: _____

Name of drug store most frequently used _____

PLEASE COMPLETE AND SIGN BACK OF FORM

(REV 5/19:ch;rdm)

CHILDS' HEALTH HISTORY: (*VERY IMPORTANT - PLEASE FILL OUT COMPLETELY*)

Does your child have any medical problems? Yes___ No___ Explain (if yes) _____

Does your child wear glasses? ___Yes___No (If Yes) Year purchased: _____ Purchased at (Store/Business) _____

Date of Last Eye Exam _____//_____//_____ **Doctor** for last exam: Dr. _____

Please check if your child has or has had the following:

__Chicken Pox	__Frequent Colds	__Meningitis	__High Blood Pressure	__ Immunizations up-to-date Y___ N ___
__Seizures	__Asthma	__Serious Injuries	__Thyroid Problems	
__Kidney Problems	__Anemia	__Blood Transfusions	__Cancer	
__Eye Problems	__Hearing Problems	__Speech Problems	__Glaucoma	__ Secondhand Smoke Exposure Y ___ N ___
__Heart Problems (*Murmur, mitral valve prolapse)*	__Developmental Problems	__Ear Infections	__Cataracts	
	__Bleeding disorder	__Diabetes	__Retinal Disease	

Please explain any items checked_____

Please list regular medications taken_____

Does your child have any "learning disabilities"? Yes___ No___ Explain (if yes) _____

Does your child have allergies to medication(s), or anything else? Yes___ No___

Explain (if yes) _____

FAMILY HEALTH HISTORY: *(PLEASE FILL OUT COMPLETELY)*

Please use the following initials or abbreviations to identify family members who have had any of the following illnesses.

F= Father **M**= Mother **S**=Sibling (*Sister/Brother*) **MP**= Mother's Parent **FP**= Father's Parent

__Heart Disease	__Mental Retardation	__Sickle Cell Trait	__Kidney Disease	__Birth Defects
__High Blood Pressure	__Stroke	__Sickle Cell Disease	__Birth Defects	__Tuberculosis
__Seizures	__Asthma	__Cancer	__Diabetes	__Mental Illness

LEGAL GUARDIAN CONSENT AND ACKNOWLEDGEMENT

I consent for my child or myself (if 18 years or older), to receive healthcare services provided by the state-licensed health professionals of Aaron Henry Community Health Services Center -Mobile Unit or school based clinic. Services may include, but are not limited to:

1. Comprehensive physical/sports examination (complete medical examination).
2. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
3. Medical care and treatment, including diagnosis of acute and chronic illness and disease, dispensing and prescribing of medications and immunizations.
4. Dental examinations including: diagnosis and sealants, fluoride application where available.
5. Routine eye screenings, diabetic retinopathy and glaucoma screenings, and process eyeglass prescriptions.
6. Referrals for service not provided by mobile unit or school based clinic.
7. Release of my child's health information from AEHCHC to your child's school district upon request.

I have read and understand the services listed above and my signature provides consent for my child to receive services provided by the Aaron E. Henry Community Health Services Center-Mobile Unit or school based clinic.

Signature of Parent or Guardian _____**Date**_____/_____/_____

(Must be signed in order to be seen)

Please call (662) 645-6008 or (662) 624-4292 for more information.

(REV 5/19:ch;rdm)