2009-2010 ROANOKE ADOLESCENT HEALTH PARTNERSHIP

PARENTAL PERMISSION FORM

(Confidential Information to be completed in ink by parent/guardian)

Return to: School/Hall Secretary at Home School

OR

Mail Directly to: RAHP. P.O. Box 12712, Roanoke, VA 24027-2712

Should you have any questions, please call 857-7284

Student's Name ____________________________ Student Social Security # ______________________
(Last) (First) (MI)

Address ____ City/State ____________ Zip ________

Home Phone ________________ Student's Cell # ________________ Date of Birth ________________

Sex: Male Female Race _____ Name of School _______________________ Grade _________

Name of Parent(s) / Legal guardian(s) ____

Work # ______________________________ (Cell #) ____________________________________

Emergency Contact Person ___________________ Phone No. __________ Relation to Student ______

Student's doctor/clinic _____________________________________ Phone ______________________

Student's dentist ____ Phone ________________

IS STUDENT COVERED BY <u>ANY</u> TYPE OF HEALTH INSURANCE? YES NO (MARK ONE)
IF YES, THE FOLLOWING INFORMATION IS REQUIRED:

Insurance company __________________________________ Address _________________________

Policyholder's Name ________________________________ Insurance policy # __________________

Group # ______________________________________ Effective Date ________________________

(If no insurance, you may wish to call 857-7600, ext. 266 to inquire about free health insurance.)

Is student under medication or treatment on a continuing basis? Yes ☐ No ☐ (mark one) If YES, please

specify medicine or treatment____

Please list all ALLERGIES (medicine, food, insect bites or other) that student may have:

I hereby give permission for the exchange of information pertaining to the School Entrance Health Form as related to immunizations and school entrance physicals for purposes of state immunization compliance.

IMPORTANT! Before signing, please read information on reverse side of this form.

I give permission for (student's name)___________________________________to receive <u>ALL</u> services provided by the Teen Health Centers, to participate in surveys on a volunteer basis, and for information to be released to our insurance company (if any) for billing purposes

Signed:________________________________ Phone #________________ Date________________
(Parent/Guardian)

ROANOKE ADOLESCENT HEALTH PARTNERSHIP
TEEN HEALTH CENTERS (*AGES 10-19 ELIGIBLE FOR SERVICES*)

2009-2010 PARENTAL CONSENT FORM FOR FLEMING TEEN HEALTH CENTER– 853-1368, PATRICK HENRY TEEN HEALTH CENTER– 777-2481, AND HURT PARK TEEN HEALTH CENTER – 857-7284

Patients of the Teen Health Centers are eligible for services listed below if parental consent is obtained. This consent is valid at each of the Roanoke Adolescent Health Partnership's Teen Centers during the school year.

RESPONSIBILITIES OF THE TEEN HEALTH CENTER

-Provide medically necessary health assessment, education, counseling and intervention with the resources available
-Encourage and support the development of healthy lifestyles including communication with parents/guardians
-Develop student's skills in use of community health care resources for life-long health
-Respect parent's/guardian's concern for student's well-being and desire to be informed
-Respect student's need for caring health services and need for privacy and confidentiality and encourage students to discuss all treatments with parents/guardians
-Respect the school's instructional time and facilities
-Work with the student's doctor in providing health care; help students who have no doctor find one

RESPONSIBILITIES OF THE STUDENT

-Keep appointments and follow recommended treatments, medications and referrals
-Respect the rights of other students to a quiet, confidential visit to the Teen Health Center
-Respect Teen Health Center and school staff with appropriate behavior when using the Teen Center

____
Student's Signature Date

RESPONSIBILITIES OF THE PARENT/GUARDIAN

-If available, identify the name of a doctor or clinic who provides the students with regular health care
-Respect the student's concern with their own personal health and their need for privacy
-Follow through with identified health needs
-Provide health insurance information (if any)

EVALUATION OF PROGRAM SERVICES

In order to improve our services, students may be asked to complete confidential questionnaires/surveys concerning health-related issues, high-risk behaviors, and/or clinic services.

SERVICES AVAILABLE WILL INCLUDE, BUT MAY NOT BE LIMITED TO

-General physical examinations
-Treatment for minor illnesses or injuries
-Referrals for serious illnesses or injuries
-Routine lab testing
-Treatment for skin problems
-Screening and treatment for sexually transmitted diseases
-Services for school and personal problems
-Preventive dental services
-Immunizations and skin test for tuberculosis
-Health education
-Prescription and dispensing of medication
-Birth control prescriptions
-Family planning education and medical care
-Pregnancy detection and referral for prenatal care
-Testing for high blood pressure, diabetes, scoliosis, hearing and vision ----

Revised 5-19-09