Sports Physical Requirements

Must have this information/items

1. All forms **MUST** be **Completed Thoroughly and Signed**
2. **MUST** have **glasses or contacts** on, on the day of event
3. List of Medication (if any is taken on a daily basis)
4. List of Medical History of patient and/or family members

   *Registration packet, the 3rd sheet is the actual Medical History form, circle all that applies or attach separate sheet with conditions.

5. Clearance letters (if patient was not playing during school year)

Memorial Hermann Healthcare System

Acknowledgement of Receipt of Joint Notice of Privacy Practices

PURPOSE: This form is used to document (a) a parent/guardian acknowledgement of receipt of Memorial Hermann Healthcare System's Joint Notice of Privacy Practices or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

I (parent/guardian) understand that the student's health information will be used and disclosed according to Memorial Hermann Healthcare System's Joint Notice of Privacy Practices.

I (parent/guardian) also understand that a written authorization from me (parent/guardian) will be requested by the clinic prior to releasing health care information for any use or disclosure not listed in the Joint Notice.

I acknowledge receiving Memorial Hermann Healthcare System's Joint Notice of Privacy Practices.

Signature	Date	School
Relationship to Student		Student Name

STAFF USE ONLY – DO NOT WRITE BELOW THIS LINE

Good Faith Effort to Obtain Acknowledgement of Receipt of Joint Notice or Privacy Practices:
Describe your good faith effort to obtain the parent/guardian signature on this form:

Staff Signature	Date

Memorial Hermann Hospital System, Memorial Hermann Continuing Care Corporation, Memorial Hermann Affiliated Services, Memorial Hermann Physicians of Texas, Memorial Hermann Ventures, Inc., Memorial Hermann Health Network Providers, Inc., and Physicians and Allied Professionals with privileges to practice at a Memorial Hermann Healthcare System Facility.

Memorial Hermann Centro De Salud

Notificación Unida de Actos de Privacidad

PROPOSITO: Esta forma es usada para documentar (a) que los padres/guardián recibieron el reconocimiento de Memorial Herman Centro de Salud Notificación Unida de Actos de Privacidad ó (b) si no hemos obtenido este reconocimiento, nuestra buena fe de esfuerzo de obtener el reconocimiento.

Yo (padre/guardian) entiendo que la información del estudiante va a ser usada y revelada de acuerdo a Memorial Hermann Sistemas de Centro de Salud Unida de Actos de Privacidad.

Yo (padre/guardián) también entiendo que la autorización escrita de parte de mi (padre/guardián) será solicitada por la clínica antes de entregar información sobre la salud para cualquier uso ó revelación que no esta en la lista de Notificación Unida.

Yo reconozco haber recibido el Memorial Hermann Sistemas de Centro de Salud Notificación Unida de Actos de Privacidad.

_____ _____ _____

Firma Fecha Escuela

_____ _____

Relación al Estudiante Nombre de Estudiante

PARA USO DE LA CLINICA-NO ESCRIBA DEBAJO DE ESTA LINEA

Tratado de buena fe de obtener reconocimiento de haber recibido la Notificación Unida de Actos de Privacidad:
Describa su buena fe y esfuerzo de obtener la firma del padre/guardián en esta forma:

_____

_____

_____

_____

_____ _____

Firma del Personal Fecha

*Date registered:*_____

Memorial Hermann Health Centers for Schools
PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (Middle) _____

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

Social Security #: _____ Birth Date: _____ Sex: *Male Female*

School: _____ Grade: _____ Student ID#: _____

Marital Status: *Single Married* Primary language spoken at home: _____

Race: *Asian/Pacific Islander African American Caucasian Hispanic NativeAmerican Other*

HEALTH INSURANCE INFORMATION.

Primary Insurance: *Medicaid CHIP Private Insurance Harris Health (Gold Card) No Insurance*

If Medicaid/CHIP, Policy #: _____ Plan Name: _____

If Private Insurance, Plan Name: _____

Does your child qualify for free or reduced lunch at school? YES ____ NO ____

PERSON RESPONSIBLE FOR THE PATIENT.

Relationship: _____ E-mail: _____

Name: (Last) _____ (First) _____ (Middle) _____

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

Day Phone #: _____ Alternate Day Phone #: _____

EMERGENCY CONTACT INFORMATION (To be contacted if parent/guardian cannot be reached).

Relationship: _____ E-mail: _____

Name: (Last) _____ (First) _____ (Middle) _____

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

Day Phone #: _____ Alternate Day Phone #: _____

Revised: 05/2019

*Date registered:*_____

Memorial Hermann Health Centers for Schools
REGISTRO DEL PACIENTE

Nombre:(Apellido)_____(Primero)_____ (Segundo)_____

Dirección: _____ Ciudad: _____ Estado: _____ Zona Postal: _____

Seguro Social #_____ Fecha de Nacimiento: _____ Sexo: *Masc* *Fem*

Escuela:_____ Grado: _____ Numero de ID#: _____

Estatus Marital: *Soltero* *Casado* Lenguaje en casa: _____

Raza: *Isleño Asiático/Pacifico* *Afro-Americano* *Caucásico* *Hispano* *Nativo Americano* *Otro*

INFORMACION DE SEGURO DE SALUD.

Seguro Primario: *Medicaid* *CHIP* *Seguro Privado* *Salud de Harris (Tarjeta dorada)* *No Seguro*

Para Medicaid/CHIP, Póliza #: _____ Nombre de Seguro: _____

Nombre de Seguro Privado: _____

Si hijo/a califica para alimentos gratis o reducido en la escuela? SI _____ NO _____

PERSONA RESPONSIBLE DEL PACIENTE.

Relación: _____E-mail: _____

Nombre:(Apellido)_____(Primero)_____ (Segundo)_____

Domicilio: _____ Ciudad: _____ Estado: _____ Zona Postal: _____

Numero teléfono #: _____ Alternativo #: _____

INFORMACION DE CONTACTO DE EMERGENCIA **(En caso que el padre o tutor no pueda ser localizado).**

Relación: _____E-mail: _____

Nombre:(Apellido)_____(Primero)_____ (Segundo)_____

Domicilio: _____ Ciudad: _____ Estado: _____ Zona Postal: _____

Numero de teléfono #: _____ Alternativo #: _____

Revised: 05/2019

Memorial Hermann Health Centers for Schools
History Form

Student Name: _____ **Date:** _____

Current Medications: _____

Medication Allergies: ☐ NO ☐ YES **Which medication?** _____ **What happens?** _____

Student's Medical History *(Check all problems since birth):*

Hospitalized: ☐ Never been hospitalized ☐ Hospitalized for: _____ When: _____

Past Surgery: ☐ Appendectomy ☐ Circumcision ☐ PE tubes in ears ☐ Tonsillectomy ☐ Umbilical or groin hernia repair
☐ Other surgery: _____ When: _____ ☐ Never had surgery

Head and Eyes: ☐ Dental caries ☐ Hearing loss ☐ Near sighted ☐ Recurrent ear infection ☐ Seasonal allergies ☐ Strabismus
☐ Wears glasses or contact lenses

Respiratory: ☐ Asthma ☐ Pneumonia ☐ RSV

Heart: ☐ Heart problem ☐ Heart murmur ☐ High blood pressure

GI: ☐ Constipation ☐ GERD (reflux)

Endocrine: ☐ Diabetes Type 1 or Type 2 ☐ Thyroid problem

Urinary: ☐ Bed wetting ☐ Kidney infection ☐ Undescended or absent testicle ☐ Recurrent bladder/urine infections

Skin: ☐ Acne ☐ Eczema ☐ Contact dermatitis

Nutrition: ☐ Food allergy ☐ Lactose intolerance ☐ Weight problem

Blood problem or Cancer: ☐ Iron deficiency anemia ☐ Sickle cell trait or disease **Cancer Type:** _____

Nervous or Muscle Systems: ☐ Febrile seizure ☐ Fracture ☐ Head trauma/concussion ☐ Migraines ☐ Scoliosis ☐ Seizures

Development: ☐ ADHD ☐ Anxiety ☐ Autism ☐ Behavior problem ☐ Depression ☐ Developmental delay
☐ Learning problem ☐ Speech problem

Any other problems: _____

Girls: Age at 1st period: _____ ☐ Regular ☐ Not Regular **Time between periods usually:** _____ **# days on period** _____

Bad cramps: ☐ No ☐ Yes **Skipped or missed periods in past year:** ☐ No ☐ Yes **How long until period started again?** _____

Family History *(which family member has the problem – mother, father, grandparent, aunt, uncle, brother or sister):*

☐ No health problems (unremarkable) ☐ do not know (unknown)

	Mother	Father	Grandparent	Aunt	Uncle	Brother	Sister
Diabetes: ☐ Type 1 ☐ Type 2							
High Blood Pressure							
Heart Disease							
Stroke							
Mental Health Disease or Problem Diagnosis: _____							
Cancer Type: _____							
Other problems: _____							

Social History: Lives with: _____ Immunizations: ☐ Up to date ☐ Needs: _____

Smokers at home: ☐ No ☐ Yes **If YES:** ☐ Inside ☐ Outside ☐ Both ☐ Pets: _____

Patient / Guardian Signature	Print Name	Relationship to patient	Date

MEMORIAL HERMANN

History Form for the Health Centers for Schools

16415 (9/19)

Centros de salud de Memorial Hermann para las escuelas
Formulario de antecedentes

Nombre del estudiante: _____ **Fecha:** _____

Medicamentos que toma actualmente: _____

Alergias a medicamentos: ☐ **NO** ☐ **SÍ** **¿Qué medicamento?** _____ **¿Qué sucede?** _____

Antecedentes médicos del estudiante *(Marcar todos los problemas desde el nacimiento):*

Hospitalizaciones: ☐ **Nunca ha sido hospitalizado** ☐ **Hospitalizado por:** _____ **¿Cuándo?:** _____

Cirugías anteriores: ☐ Apendicectomía ☐ Circuncisión ☐ Tubos ecualizadores de presión en los oídos ☐ Amigdalectomía ☐ Reparación de hernia umbilical o inguinal ☐ Otra cirugía: _____ Fecha: _____ ☐ Nunca tuve una cirugía

Cabeza y ojos: ☐ Caries dentales ☐ Discapacidad auditiva ☐ Miopía ☐ Infecciones recurrentes del oído ☐ Alergias estacionales ☐ Estrabismo ☐ Uso de anteojos o lentes de contacto

Sistema respiratorio: ☐ Asma ☐ Neumonía ☐ Virus sincicial respiratorio (VSR)

Corazón: ☐ Problemas cardíacos ☐ Soplo cardíaco ☐ Hipertensión arterial

Sistema GI: ☐ Estreñimiento ☐ GERD (reflujo)

Sistema endocrino: ☐ Diabetes tipo 1 o tipo 2 ☐ Problema de tiroides

Sistema urinario: ☐ Enuresis ☐ Infección renal ☐ Testículos no descendidos o ausentes ☐ Infecciones de la vejiga/urinarias recurrentes

Piel: ☐ Acné ☐ Eccema ☐ Dermatitis de contacto

Nutrición: ☐ Alergia alimentaria ☐ Intolerancia a la lactosa ☐ Problemas de peso

Problemas sanguíneos o cáncer: ☐ Anemia por deficiencia de hierro ☐ Rasgo drepanocítico o anemia falciforme
Tipo de cáncer: _____

Sistema nervioso o muscular: ☐ Convulsiones febriles ☐ Fracturas ☐ Traumatismo de cráneo/contusión ☐ Migrañas ☐ Escoliosis ☐ Convulsiones

Desarrollo: ☐ TDAH ☐ Ansiedad ☐ Autismo ☐ Problemas de comportamiento ☐ Depresión ☐ Retraso del desarrollo ☐ Problemas de aprendizaje ☐ Problemas del habla

Cualquier otro problema: _____

Niñas: Edad del 1.er período menstrual: _____ ☐ Regular ☐ Irregular **Plazo habitual entre los períodos menstruales:** _____
Núm. de días del período _____

Calambres: ☐ No ☐ Sí **Falta e irregularidades en el periodo en los últimos años:** ☐ No ☐ Sí
¿Cuánto tiempo pasó hasta el siguiente período menstrual? _____

Antecedentes familiares *(qué miembro de la familia tiene el problema: madre, padre, abuelo, abuela, tía, tío, hermano o hermana):*

☐ **Ningún problema de salud (no relevante)** ☐ **No conocido (desconocido)**

	Madre	Padre	Abuelos	Tía	Tío	Hermano	Hermana
Diabetes: ☐ Tipo 1 ☐ Tipo 2							
Hipertensión							
Enfermedad del corazón							
Accidente cerebrovascular							
Enfermedad o problemas de salud mental Diagnóstico: _____							
Tipo de cáncer: _____							
Otros problemas: _____							

Antecedentes sociales: Vive con: _____ Vacunas: ☐ Actualizadas ☐ Necesarias: _____

Fumadores en el hogar: ☐ No ☐ Sí **En caso afirmativo:** ☐ Adentro ☐ Afuera ☐ Ambos ☐ Mascotas: _____

Firma del paciente/tutor	Nombre en letra de imprenta	Relación con el paciente	Fecha

MEMORIAL HERMANN

History Form for the Health Centers for Schools

16415 (9/19)

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____ When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name Stephen Dixon Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS HOGG CLINIC, HOUSTON, TEXAS

INFORMED CONSENT FOR TREATMENT AND OTHER PREVENTIVE HEALTH CARE SERVICES

PLEASE READ CAREFULLY AND FILL OUT THE CONSENT FORM BELOW FOR YOUR STUDENT TO BE TREATED AT THE HEALTH CENTER

Memorial Hermann Health Centers for Schools (MHHCS) or "Health Center" is concerned with the health of students at contracted schools. We provide a number of health care services, subject to the limitations of the facility.

THE FOLLOWING HEALTH CARE SERVICES ARE AVAILABLE AT THE HOGG SCHOOL-BASED HEALTH CENTER.

1. Immunizations
2. Well Exams / Check-ups
3. Athletic and Camp Physicals
4. Health Education
5. Nutrition Education
6. Family Planning Services
7. Social Service Assistance
8. Treatment of minor illness and injury
9. Mental Health counseling
10. Exercise education and counseling
11. Detection and treatment of sexually transmitted diseases (STD)

Please indicate which of the following apply to the student:

☐ Medicaid # _____ Medicaid Plan _____ ☐ Harris Health/Gold Card

☐ CHIP ☐ Private Health Insurance ☐ No Insurance

IMPORTANT – PLEASE NOTE: The Health Center is a Medicaid Provider and will bill Medicaid for services to those students who have Medicaid coverage. **Non covered services will NOT be billed to the student or family.**

I authorize MHHCS to bill Medicaid or my Medicaid plan and receive payment directly from them for services rendered. I also authorize MHHCS to release information as required to Medicaid or my Medicaid plan, for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. A photocopy or a telefaxed copy of this authorization shall be deemed as valid as the original.

I authorize the Health Center staff to disclose to the school nurse, medical or athletic team appropriate health information about my child as deemed necessary, solely for treatment purposes, and for the continuity of my child's care. I further authorize school personnel to disclose grades, absenteeism, and disciplinary data for my child, if seen by the Licensed Clinical Social Worker or Licensed Professional Counselor.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

PLEASE NOTE:

Primary health care services are provided to students by a full time Advanced Practice Provider. In addition, counseling services are provided by a Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC). Services provided at the Health Center are optional and at no cost to the student or family.

I authorize a designated MHHCS professional healthcare provider to provide necessary and/or advisable treatment for the student.

_____ _____

Student Name Date of Birth

I give my permission for MHHCS to provide all services indicated above within the capabilities of the facility and its personnel except for

item(s) _____.

I authorize the above named facility to provide transportation and/or accompany my child from the contracted schools to the Health Center for services after receiving permission from the school nurse.

I have read and completed this consent form. I understand that school personnel may see this informed consent. I understand that any questions I may have concerning the Health Center will be answered by calling (713) 864-7614.

XX _____ _____ _____ _____

Parent / Guardian Signature **Print Name** **Relationship to Student** **Date**

Phone number where parent/guardian can be reached during school hours:

Name:_____ Phone Number:_____ Best time to call:_____

Email:_____

Second Parent/Guardian
Signature (optional):: _____ Phone Number:_____ Best time to call:_____

MEMORIAL HERMANN

Informed Consent

16266 (3/20)

MEMORIAL HERMANN HEALTH CENTERS FOR SCHOOLS HOGG CLINIC, HOUSTON, TEXAS

CONSENTIMIENTO INFORMADO PARA EL TRATAMIENTO Y OTROS SERVICIOS DE ATENCIÓN DE LA SALUD PREVENTIVA

LEA DETENIDAMENTE Y COMPLETE EL SIGUIENTE CONSENTIMIENTO INFORMADO PARA QUE SU ESTUDIANTE SEA TRATADO EN EL CENTRO DE SALUD

Memorial Hermann Health Centers for Schools (MHHCS) o "Centro de salud" se interesa por la salud de los estudiantes en las escuelas con las cuáles tenemos un contrato. Brindamos un número de servicios de atención de la salud, sujetos a las limitaciones del establecimiento.

LOS SIGUIENTES SERVICIOS DE ATENCIÓN DE LA SALUD ESTÁN DISPONIBLES EN EL CENTRO DE SALUD HOGG DENTRO DE LAS ESCUELAS

1. Inmunizaciones
2. Exámenes de rutina / Chequeos médicos
3. Exámenes físicos para campamento y deporte
4. Educación sobre la salud
5. Educación sobre la nutrición
6. Servicios de planificación familiar
7. Asistencia de servicio social
8. Tratamiento de enfermedades o lesiones leves
9. Consejería de salud mental
10. Consejería y educación sobre el ejercicio
11. Detección y tratamiento de las enfermedades de transmisión sexual (STD, por sus siglas en inglés)

Indique cuál de los siguientes se aplica al estudiante:

☐ N.° de Medicaid _____ Plan de Medicaid _____ ☐ Harris Health/Gold Card

☐ CHIP ☐ Seguro de salud privado ☐ Sin seguro

IMPORTANTE – TENGA EN CUENTA QUE: El Centro de salud es un proveedor de Medicaid y facturará a Medicaid por los servicios a aquellos estudiantes que tienen cobertura Medicaid. **Los servicios que no estén cubiertos, NO se cobrarán al estudiante o a la familia.**

Yo autorizo a MHHCS para que cobren a Medicaid o a mi plan de Medicaid y reciban directamente el pago de ellos por los servicios prestados. También autorizo a MHHCS para que divulgue información según sea requerida por Medicaid o por mi plan de Medicaid con el propósito de determinar los beneficios. Comprendo que dichos registros pueden incluir información con respecto a pruebas de VIH/SIDA, abuso de sustancias y/o problemas de salud mental. Una fotocopia o una copia enviada por fax de esta autorización deberá considerarse tan válida como el documento original.

Yo autorizo al personal del Centro de salud a divulgar a la enfermera, al equipo médico o al equipo deportivo de la escuela la información de salud adecuada sobre mi hijo/a según se considere necesario, únicamente para los propósitos del tratamiento y para la continuidad de la atención médica de mi hijo/a. Autorizo también a que el personal de la escuela divulgue las calificaciones, inasistencias e información de disciplina de mi hijo/a si él/ella es visitado(a) por el trabajador social con licencia de la clínica o el consejero profesional licenciado.

XX _____ _____ _____ _____

Firma del padre/tutor | **Nombre en letra de imprenta** | **Relación con el estudiante** | **Fecha**

TENGA EN CUENTA:

Un proveedor de prácticas avanzadas brinda servicios de atención primaria a tiempo completo a los estudiantes. Adicionalmente, los servicios de asesoramiento son proporcionados por un trabajador social con licencia de la clínica (LCSW, por sus siglas en inglés) o un consejero profesional licenciado (LPC, por sus siglas en inglés). Los servicios brindados en el Centro de salud son opcionales y sin costo alguno para el estudiante o la familia.

Yo autorizo a un proveedor de atención de la salud profesional designado de MHHCS a brindar el tratamiento recomendado y/o necesario para el estudiante.

_____ _____

Nombre del estudiante | Fecha de nacimiento

Yo doy mi consentimiento a MHHCS para brindar todos los servicios indicados anteriormente dentro de las posibilidades del establecimiento y su personal con excepción de lo(s) siguiente(s) _____.

Yo autorizo al establecimiento mencionado anteriormente a brindar el transporte y/o acompañar a mi hijo/a desde las escuelas con contrato hasta el Centro de salud para obtener los servicios después de recibir el consentimiento de la enfermera de la escuela.

He leído y completado este formulario de consentimiento. Entiendo que el personal de la escuela puede ver este consentimiento informado. Entiendo que cualquier pregunta que pueda tener en relación al Centro de salud será respondida llamando al (713) 864-7614.

XX _____ _____ _____ _____

Firma del padre, la madre o el tutor | **Nombre en letra de imprenta** | **Relación con el estudiante** | **Fecha**

Número de teléfono para comunicarse con el padre, la madre o el tutor durante el horario escolar:

Nombre:_____ Número de teléfono:_____ La mejor hora para recibir llamadas:_____

Correo electrónico:_____

Firma del segundo progenitor o tutor(opcional): _____ Número de teléfono:_____ La mejor hora para recibir llamadas:_____

MEMORIAL HERMANN

Informed Consent