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 | L-BASED HEALTH CENTER. | | |
|---|--|--|----------------------|--|
| 1. Immunizations | Nutrition Education | Mental Health counseling | | |
| 2. Well Exams / Check-ups | 6. Family Planning Services | Exercise education and could | | |
| | 7. Social Service Assistance | 11. Detection and treatment of s | sexually transmitted | |
| Health Education | Treatment of minor illness and injury | diseases (STD) | | |
| Please indicate which of the following apply to t | he student: | | | |
| ☐ Medicaid # | Medicaid Plan | | Health/Gold Card | |
| ☐ CHIP ☐ Private Health Insurance ☐ No Ins | surance | | | |
| IMPORTANT – PLEASE NOTE: The Health C Medicaid coverage. Non covered services w | | | ents who have | |
| I authorize MHHCS to bill Medicaid or my Medic MHHCS to release information as required to M records may include information regarding HIV/s copy of this authorization shall be deemed as v | ledicaid or my Medicaid plan, for the purpo AIDS testing, substance abuse, and/or me | ose of determining benefits. I und | erstand that such | |
| I authorize the Health Center staff to disclose to deemed necessary, solely for treatment purpos grades, absenteeism, and disciplinary data for | es, and for the continuity of my child's care | e. I further authorize school perso | nnel to disclose | |
| XX | | | | |
| Parent / Guardian Signature | Print Name | Relationship to Student | Date | |
| are provided by a Licensed Clinical Social V Health Center are optional and at no cost to I authorize a designated MHHCS professional I | the student or family. | | | |
| Student Name | | Date of Birth | | |
| | ervices indicated above within the capabilities of the facility and its personnel except for | | | |
| I give my permission for MHHC5 to provide all | services indicated above within the capab | illities of the facility and its person | ici except ioi | |
| item(s) | | | | |
| I authorize the above named facility to provide for services after receiving permission from the | transportation and/or accompany my child school nurse. | from the contracted schools to the | e Health Center | |
| I have read and completed this consent form. questions I may have concerning the Health Co | I understand that school personnel may se enter will be answered by calling (713) 864 | ee this informed consent. I unders 4-7614. | stand that any | |
| 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 ca | II: | |
| Email: | | | | |
| Second Parent/Guardian | Diama Number | Doct time to co | ıll: | |
| Signature (optional):: | Phone Number: | Dest time to ca | | |

MEMARIAI.

Informed Consent

