



**Outreach Consent Form**

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) will be providing outreach services at your child's school this year. All children are invited to participate in CHC/SEK's outreach program. No child will be denied services based on insurance status or ability to pay. However, insurance, if available, will be billed. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please call **620-240-5061**. *Please complete this form in ink.*

**School Name:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Race:**

- American Indian or Alaskan Native
- White
- Native Hawaiian or Other Pacific Islander
- Asian
- Black or African American
- Other Race

**Ethnicity (circle one):** Hispanic or Latino -OR- Not Hispanic or Latino

**Do you want access to your medical records electronically? (circle one) YES OR NO**

IF yes, Email Address: \_\_\_\_\_  
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL)

**Does the child have medical insurance? (circle one) YES OR NO**

If YES, complete the insurance section below. CHC/SEK will bill your insurance for services provided.

- KanCare (Amerigroup, United Health Care, Sunflower) # \_\_\_\_\_
- Medicaid (Oklahoma or Missouri) # \_\_\_\_\_
- Commercial/ Private Insurance

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Consent:** As parent or legal guardian of the child named above, I give Community Health Center of Southeast Kansas, Inc. permission to provide my child with medical outreach services by CHC/SEK healthcare professionals. This consent is valid for one (1) year from the Parent/ Guardian Signature date below.

X Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Please complete and sign the Medical History Form on the other side\***

**Medical History Form**

Student Name: \_\_\_\_\_ DOB \_\_\_\_\_

**Medical History: Please check all that apply**

Heart Condition:  Heart Murmur  Congenital Heart Disorder  Other: \_\_\_\_\_

Lung Condition:  Asthma  Cystic Fibrosis  Other: \_\_\_\_\_

Endocrine Condition:  Diabetes  Thyroid Disorder  Other: \_\_\_\_\_

Neurologic Condition:  Seizure Disorder  Concussion  Other: \_\_\_\_\_

Bone/Joint Condition:  Pins/Screws  Rheumatoid Arthritis  Other: \_\_\_\_\_

Infectious Condition:  Hepatitis  HIV  Other: \_\_\_\_\_

Behavioral Health:  Anxiety  Depression  Autism Spectrum

Other: \_\_\_\_\_

Severe Allergy to:  Peanuts  Bee/wasp stings  Other: \_\_\_\_\_

Reaction: \_\_\_\_\_

Other Condition(s): \_\_\_\_\_

**Does your child have special health care needs? (circle one) YES OR NO**

IF yes, please explain: \_\_\_\_\_

**Surgeries/Hospitalizations? (circle one) YES OR NO**

IF yes, please explain: \_\_\_\_\_

**Please list any known allergies (medications, foods, etc.):** \_\_\_\_\_

**Please list all medications your child is currently taking (including over the counter medications):** \_\_\_\_\_

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

X Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_