



BAPTIST HEALTH & FOUR RIVERS BEHAVIORAL HEALTH

AT HEATH SCHOOLS

Care for minor injuries, illness and mental/behavioral health

Baptist Health and Four Rivers Behavioral Health provide on-site primary care and counseling services to students, staff and families of Heath Schools. From check-ups and vaccinations, to sick care and counseling services, our goal is to provide convenient, accessible healthcare to meet the needs of busy families.

A nurse practitioner and certified behavioral health counselor are on-site to provide the following services:

- School and sports physicals
- Minor injuries and illness care
- Vaccinations
- Behavioral healthcare
- Substance abuse counseling

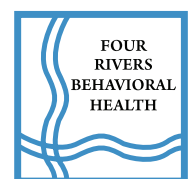
No appointment is needed.

The clinic accepts all major health insurance plans and will bill for co-payments and self-pay patients. For security reasons, no money will be collected at the clinic.

Important: All students under 18 must have a signed consent form on file in the clinic. If your child requires care, we will contact the individual on the consent form before providing care.



BAPTIST HEALTH®



For more information, call 270.538.4298



CONSENT FOR SCHOOL-BASED HEALTH CENTER

Yes - I consent for my minor child to receive health care services provided by Baptist Health and Four Rivers Behavioral Health in the school-based health center as determined by the school-based health center's staff.

- This consent will remain in effect until the end of the existing school year in which this consent was signed, or until I revoke this consent in writing and provide the revocation to the staff of Baptist Health and Four Rivers Behavioral Health.
I affirm that I have the right to consent as the parent or legal guardian of the minor child as listed below. I understand that it is my responsibility to notify Baptist Health and Four Rivers Behavioral Health about changes in my legal guardianship.
I understand that Baptist Health may notify me if my minor child received care in the school-based health center, except in the event my minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky Revised Statute 214.185.
I understand that Four Rivers Behavioral Health may notify me if my minor child received care in the school-based health center, except in the event my minor child is emancipated or able to consent for treatment without the consent of a parent or legal guardian as permitted in Kentucky Revised Statute 214.185.
I authorize Baptist Health and Four Rivers Behavioral Health and each of their staff to communicate with my minor child's health care providers about health care services rendered by Baptist Health and Four Rivers Behavioral Health at the school-based health center.
I authorize Baptist Health and Four Rivers Behavioral Health to bill my health insurance provider for health care services rendered at the school-based health center.

Student's Name Last First Middle Date of Birth (mm/dd/yy) SS#

School Grade

Home Address City State Zip

Names of Parents/Guardians

Subscriber's Name Last First Middle Date of Birth (mm/dd/yy)

SS# Subscriber's Employer

Student's Allergies (including medication allergies)

Pharmacy of Choice Pharmacy Phone #

Emergency Contact Relationship to Student Phone #

Name of Child's Doctor/Office Phone #

Doctor/Office Address

Name of Health Insurance or HMO

Medical Care Number (The school-based health center will need a copy of your card, front and back)

Confidentiality: The information in my minor child's medical record is confidential and, unless as authorized by law, will not be released to any unauthorized person or agency without my authorization. However, I understand that it may be necessary for staff of the school-based health center to confer among themselves and the school's health professional about treatment related to my minor child. I understand that, as a courtesy, medical records of any treatment provided to my minor child at the school-based health center will be forwarded to my minor child's family doctor.

Signature of Parent or Legal Guardian

Date