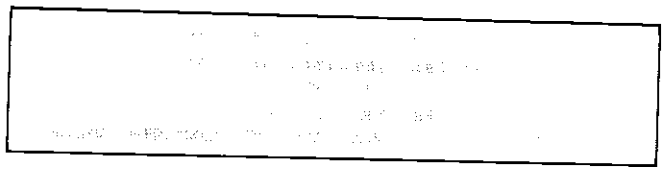

JZV

Letter of Consent for Administration of Preventative Services

This section is to be completed by a parent, guardian or child's representative.**PLEASE PRINT**

Parent/Guardian/Child Representative Name(Please circle one and print name below):

_____**Telephone Number**: _____

Email address: _____

Name of School:_____**Grade**_____**Teacher**_____

Child's Name:_____Date Of Birth: _____ Sex: M/F Race: _____

Child's SSN:_____Child'sAddress: _____

City:_____ Zip Code: _____Doctor Name_____

DoctorTelephone_____Current Medications: _____

Family Medical History: _____

(Please indicate who in the family (Grandma, Uncle etc.) was diagnosed with a disease and is still living or deceased.)

Child Past Medical History/Surgeries: _____

Current Medical Issues:_____

_____

Medication/Food Allergies: _____

Does your child have health insurance? ☐yes ☐no(If yes, please provide the ID number in the appropriate spot below):

☐Aetna ID # _____
☐Amerigroup ID #_____
☐Blue Care ID #_____
☐Blue Cross Blue Shield ID #_____
☐Cigna ID #_____

☐Health Springs ID # _____
☐United Health Care ID #_____
☐Other #_____
Please provide a copy of insurance card (front and back) or take a picture and send it to (615) 823-7697

Our Well Child exam includes the following in compliance with state requirements:
Physical assessment, urinalysis, diabetic screening (glucose/HbA1c), cholesterol (if child falls over 85% of weight), nutrition assessment, behavioral assessment, sports physical (if needed), obesity screening (BMI), high blood pressure screening, hearing screening, and vision screening. Parent/Guardian signing this form will receive a post evaluation sheet with information regarding the results/outcomes and contact information for the providers.

OUR COMMITMENT:
ProHealth is a federally qualified health center. All information is kept confidential in accordance with HIPPA rules and regulations.

I understand that by signing this form I am consenting for the child named above to receive preventative services listed above offered by ProHealth Community Health Center. Your insurance will be billed for this physical exam. This physical exam will count as your child's yearly exam. Co-pay fees will **not** be applicable. If the child has no insurance, all fees will be waived. Any abnormalities will be communicated to the parent that completed the form.

***Your insurance will be billed for this well child exam.These exams are the same as an annual visit to a primary provider or optometrist. Please be aware that TennCare, Private/Commercial insurances and CoverKids will pay for only one of each of these exams per year. Your child can receive their sports physical from ProHealth Community Health Center or their primary care doctor.**

Parent/Guardian Signature: _____**Date:** _____ **OVER TO BACK**

CHILD'S NAME _____ Date _____

Is the child up to date with your child's immunizations? ☐yes ☐no

Does the child live in or regularly visit a house/apartment built before 1950? ☐yes ☐no☐Unsure

Does the child live in or regularly visit a house/apartment built before 1978 With recent or ongoing remodeling? ☐yes ☐no☐Unsure

Does the child have a sibling or playmate that has, or did have lead poisoning? ☐yes ☐no☐Unsure

Does your home's plumbing have lead pipes or copper pipes with lead solder joints? ☐yes ☐no☐Unsure

Has your child been in close contact with a person with infectious tuberculosis? ☐yes ☐no☐Unsure

Does child have HIV infection or considered at risk for HIV infection? ☐yes ☐no☐Unsure

Is the child foreign born, a refugee, or an immigrant? ☐yes ☐no☐Unsure

Is the child in contact with...HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers? ☐yes ☐no☐Unsure

Does the child have a depressed immune system? ☐yes ☐no☐Unsure

Does the child live in an established "high risk for tuberculosis" community or area? ☐yes ☐no☐Unsure

Does the child have risk factors for future coronary disease such as physical inactivity, obesity, or diabetes mellitus? ☐yes ☐no☐Unsure

Is there a family history of coronary or peripheral vascular disease below age 55? ☐yes ☐no☐Unsure

Is there a family history of elevated blood cholesterol? ☐yes ☐no☐Unsure

What's your child's eating habits:

Low fat milk? ☐yes ☐no

Variety of fruits, vegetables? ☐yes ☐no If yes, how many servings per day? ____

Eats breakfast? ☐yes ☐no

Eats supper with family? ☐yes ☐no

Eat at fast food restaurants, two times a week or more? ☐yes ☐no

Does the child get one hour or more of physical activity a day ☐yes ☐no