ORLANDO HEALTH®
ARNOLD PALMER HOSPITAL For Children

2600 Technology Drive Suite 200, Orlando, FL 32804

LINE UP PATIENT I.D. LABEL HERE

THIS FORM MUST BE COMPLETELY FILLED OUT

Teen Xpress Health Center Parental Consent

Please read carefully and complete the following consent statement authorizing your minor son/daughter to receive services from Teen Xpress. **The services provided by the doctor and/or nurse practitioner, therapist, dietitian and case manager with Teen Xpress are free and include:**

- Comprehensive physical exam
- Medication and immunization
- Referrals
- Diagnosis and treatment
- Mental health counseling
- Nutrition education

Son/Daughter Legal Name as it appears on birth certificate: ______

Date of Birth: ____/____/____ (mm dd yyyy) Sex: M or F, other Grade: ______ Site/School Name: ______

Parent/Legal Guardian: ______ Phone Number: ______

Address: ______ Apt.#______ City/State/Zip: ______

Emergency Contact Name: ______ Emergency Contact Number: ______

Emergency Contact Relationship: ______ Parent/Guardian Email: ______

Teen Phone Number: ______ Teen Email: ______

Does your son/daughter have health insurance? ☐ Yes ☐ No If yes, name of medical insurance: ______

☐ Medicaid ☐ Private ☐ Other: ______

Name of primary care provider: ______ Date of son/daughter's last physical exam: ______

Family Medical History - To be completed by parent/guardian. *(Check all that apply)*
Have you (if blood parent) or a close relative of your child had any of the following?

☐ Anemia
☐ Bleeding Disorder
☐ Cancer Type: ______
☐ Diabetes
☐ Heart Disorder
☐ High Blood Pressure
☐ Kidney Disease
☐ Mental Health Problems
☐ Seizures
☐ Strokes
☐ Sudden Death
☐ Other: ______

Son/Daughter Medical History - To be completed by parent/guardian. *(Check all that apply)*
Has your son/daughter had any of the following?

☐ Anemia
☐ Asthma
☐ Back Pain
☐ Bladder Infection
☐ Chest Pain
☐ Concussion/Fainting
☐ Deafness
☐ Diabetes
☐ Dislocation of a joint tendon or bone
☐ Earaches
☐ Excessive Bleeding
☐ Eye Injury
☐ Fractures
☐ Frequent Dizziness
☐ Glasses/Contacts
☐ Headaches
☐ Heart Disease
☐ Heart Murmur
☐ Heat Stroke
☐ Hernia
☐ High/Low Blood Pressure
☐ Joint Problems
☐ Kidney Problems
☐ Mental Health Problems
☐ Neck Injury
☐ Nosebleeds
☐ Pneumonia
☐ Shortness of Breath
☐ Sickle Cell Disease/Trait
☐ TB
☐ Thyroid Disease
☐ Ulcers
☐ Unexplained Fever
☐ Weight problems
☐ Attention Deficit Disorder (ADD)
☐ Attention Deficit Hyperactivity Disorder
☐ Other: ______

Provide details to any items checked above: ______

Has your son/daughter had surgery? ☐ Yes ☐ No If yes, what type? ______ At what age?: ______

Has your son/daughter been hospitalized? ☐ Yes ☐ No If yes, reason: ______ At what age?: ______

Did your son/daughter receive care in the emergency department in the last 12 months? ☐ Yes ☐ No What for? ______

Is your son/daughter taking any medications, vitamins or home remedies? ☐ Yes ☐ No If yes, what? ______

Does your son/daughter have any medication allergies? ☐ Yes ☐ No If yes, to what? ______

Does your son/daughter have any food allergies? ☐ Yes ☐ No If yes, to what? ______

I understand that federal law requires the confidentiality of the patient's medical record, and the record will not be released to any person or entity other than healthcare provider without prior permission from me.

I understand that some information such as background history and test scores may be used for evaluation purposes and reported to outside funders with no personal identifiers attached to the data.

I hereby release Orlando Health, their affiliates, directors, officers, employees, agents, successors and assigns from any and all liability arising from or in any way connected to my son/daughter receiving services from Teen Xpress.

______ Parent/Legal Guardian (Print Name) Date Time

______ Parent/Legal Guardian (Signature) Date Time

 THIS FORM MUST BE COMPLETELY FILLED OUT. THIS FORM EXPIRES ONE YEAR FROM SIGNATURE DATE.