the howard phillips center for children & families
Part of Arnold Palmer Hospital for Children

TEEN XPRESS

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.

Son/Daughter Name: _____ Social Security Number:_____

Date of Birth:____/____/____ Sex: M or F 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:_____

The services provided by the doctor and/or nurse practitioner, therapist, dietitian and case manager with Teen Xpress include:

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

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

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

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

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	❑ Diabetes	❑ Kidney Disease	❑ Strokes
❑ Bleeding Disorders	❑ Heart Disease	❑ Mental Health Problems	❑ Sudden Death
❑ Cancer	❑ High Blood Pressure	❑ Seizures	❑ 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	❑ Earaches	❑ Heart Murmur	❑ Pneumonia	❑ Other:
❑ Asthma	❑ Easy Bruising	❑ Heat Stroke	❑ Shortness of Breath	_____
❑ Back Pain	❑ Excessive Bleeding	❑ Hernia	❑ Sickle Cell Disease	_____
❑ Blackouts	❑ Eye Injury	❑ High/Low Blood Pressure	❑ Sickle Cell Trait	_____
❑ Bladder Infection	❑ Fast Heartbeat at Rest	❑ Hot/Cold Spells	❑ TB	_____
❑ Chest Pain	❑ Fractures	❑ Joint Problems	❑ Thyroid Disease	_____
❑ Concussion/Fainting	❑ Frequent Dizziness	❑ Kidney Problems	❑ Ulcers	_____
❑ Deafness	❑ Glasses/Contacts	❑ Mental Health Problems	❑ Unexplained Fever	_____
❑ Diabetes	❑ Headaches	❑ Neck Injury	❑ Weight problems	_____
❑ Dislocation of a joint tendon or bone	❑ Heart Disease	❑ Nosebleeds		_____

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?: _____

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?_____

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 MUST BE REVIEWED ONCE PER YEAR