LEAP Academy
UNIVERSITY SCHOOL

LEAP Health and Wellness Center
130 N. Broadway, 10th Floor
Camden, NJ 08102
Office: 856-614-5610
Fax: 856-614-3236

STUDENT INFORMATION

Sex/Gender: ☐ FEMALE ☐ MALE

Name:_____
Last First

Date of Birth:_____ **Social Security #**_____

Race/ Ethnicity: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Other_____
☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Hispanic/Latino

Check all that apply

Home Phone:_____ Cell Phone:_____

Address:_____ City:_____ State_____ Zip Code:_____

School Attending_____ Grade In School_____

PARENTAL/LEGAL GUARDIAN INFORMATION

Name:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Cell Phone #1 _____ Cell Phone #2_____

EMERGENCY INFORMATION

Name of Contact 1:_____ Relationship To Student:_____

Home Phone: _____ Cell Phone:_____

Name of Contact 2:_____ Relationship To Student:_____

Home Phone:_____ Cell Phone:_____

INSURANCE INFORMATION

Type Of Insurance: ☐ Medicaid ☐ HMO ☐ PPO ☐ HORIZON ☐ OTHER_____

Specific Medicaid Information: Recipient ID#:_____ Case# _____

Specific HMO/PPO/OTHER Information: Name Of HMO/PPO/OTHER:_____

Name Of Insured:_____ Policy ID #:_____ Group#:_____

Employer Name:_____ Address:_____ Phone:_____

PRIMARY PHYSICIAN INFORMATION

Student's Doctor's Name:_____ Health Center Name:_____

Address:_____ Doctor's Phone #:_____

Allergies To Medicine (s)_____ Existing Medical Condition(s)_____

I authorize and consent to the enrollment of the above-named minor, of whom I am the parent or guardian, as a patient, in the LEAP Health and Wellness Center (LEAP). I will contact my child's insurance company and have LEAP listed as my child's primary healthcare provider. I understand that copays are due at the time of service. However, if I do not accompany my child to the office visit, I will be billed for this copay and agree to pay this copay by the due date listed on my bill. While LEAP collaborates with LEAP Academy Charter School (the "School") in connection with certain activities, LEAP is a separate and distinct organization which has been issued an ambulatory care facility license by the New Jersey Department of Health. LEAP is operated by a medical director who is not a "School official", but who may interact with School officials from time to time as authorized by patients, parents/guardians of the patients and /or as required or permitted by relevant law. **My consent will allow the physician of LEAP to provide comprehensive health and counseling services to my child during attendance at school, and, to that end, I consent to School providing information to LEAP necessary to facilitate the provision of said services (e.g., class schedule, medication information, information about chronic conditions/medical history, nurse or other School officials' observations).** I understand that the LEAP physician will make reasonable efforts to contact me prior to the examination of my child in order to get past medical history and discuss my child's present illness/symptoms. I have a right to withdraw my consent and refuse services by notifying LEAP in person. Comprehensive medical care includes those services my child would receive in a doctor's office or a clinic. Such services may include, but are not limited to, school and sports physicals, care of existing medical conditions (such as, diabetes, high blood pressure, asthma), treatment of acute medical problems (such as, sore throats, colds, stomach aches), immunizations and vaccinations (including Hepatitis A, Hepatitis B, Hib, HPV, Polio, Meningococcal, MMR, Pneumococcal,

Seasonal Flu, Tdap), TB testing, health education and first aid. I further consent to follow up with any recommended testing, such as lab work, radiology studies, etc. or referral to a specialist by the physician as part of my child's care. I understand, that under New Jersey laws, my child may consent to certain types of services, including pregnancy testing, birth control methods and treatment of infections resulting from having sex and that these services are available at LEAP. I understand that the professional staff at LEAP may encourage the practice of abstinence (not having sex) in discussions with patients. I understand that no medical experimentation will be conducted on my child. I further understand that the medical records maintained by the staff are confidential and are the property of LEAP. I authorize LEAP staff to release school and sports physical forms and immunization record to the School. I authorize the School and the Camden Public Schools to release the records of previous physicals and immunizations pertaining to my child for use by the LEAP. I understand and acknowledge that in the case of a "health emergency", LEAP and the School may exchange, disclose and/or receive information to/from any other person as permitted by law in connection with the treatment of said health emergency, and I consent to the same.

Signature of Parent/Legal Guardian X_____ **Date**_____

Relationship to student: ☐ Mother ☐ Father ☐ Other(specify)_____