School-Based Health Center Enrollment Packet

INTRODUCTION AND INSTRUCTIONS:
This center is very unique being school based. It offers the students and community members access to medical care when it might otherwise not be available. We operate year round and during the school year offer NO COST transportation from the schools in the district to the health centers and back. The parents/ guardians are always welcome at the appointments, but are not required to be there. **After the first year, only items that change need to be completed. Examples - grade in school, school building, addresses, phone numbers, medical history, INSURANCE INFORMATION, etc.** ***PLEASE PUT CHILDS NAME ON EACH PAGE.*** **THANK YOU!**

ONCE CONSENTS ARE RECEIVED, WE WILL BEGIN SCHEDULING APPOINTMENTS FOR THE APPROVED SERVICES. YOU WILL RECEIVE A NOTICE OF THE APPOINTMENT TIME AND IF WE DO NOT RECEIVE A REQUEST TO CHANGE THIS, WE WILL PROCEED AS SCHEDULED.

PLEASE COMPLETE THE FOLLOWING WHITE COLOR PAGES (OTHER COLOR PAGES ARE FOR YOU TO KEEP).
PLEASE PRINT LEGIBLY OR IT MAY DELAY PROCESSING OF YOUR CHILD'S CARE.

Student's Last Name: _____ First Name: _____ M.I.:_____

Student's Current Building: _____ Current Grade: _____ Date of Birth: _____

PRIMARY CARE SERVICES:

____**YES,** I consent for my child to receive **MEDICAL CARE** including well childcare* (includes work, daycare, and sports physicals) appropriate immunizations, and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note - well childcare includes vision and hearing SCREENINGS (but not full exam), urine/ blood tests, immunizations as needed, and external genital exam when appropriate).

__**NO,** I do not wish for my child to receive **MEDICAL CARE** at the School Based Health Center (SBHC)

DENTAL SERVICES:

___**YES,** I consent for my child to receive **DENTAL SERVICES** at the school based / mobile dental office including preventative care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals, if necessary. Sealants and other preventive procedures will also be provided. The treatment plan will be provided and approved by the parents/ guardian PRIOR to starting treatment.

__**NO,** I do not wish for my child to receive **DENTAL SERVICES** at the SBHC**.**

VISION SERVICES:

__**YES,** I consent for my child to receive **VISION SERVICES,** which may include comprehensive eye examinations (including dilation), vision therapy, and fitting/ dispensing of vision correction.

__**NO,** I do not wish for my child to receive **VISION SERVICES** at the SBHC.

TRANSPORTATION SERVICES:

___**YES,** I consent form my child to be **TRANSPORTED/ACCOMPANIED** to and from the SBHC by a school designee. I, the parent or guardian of above named student, release Primary Health Solutions, its Board members, employees, and authorized agents/ representatives from any and all liability to personal injury or damage resulting from the transportation to or from the school for these purposes.

__**NO,** I do not wish for my child to be transported to or from school for these purposes

By signing this consent, I agree to the terms and conditions regarding PAYMENT FOR SERVICES & SHARING OF HEALTH INFORMATION as explained in the accompanying Program Description for. I have also received and agree with the **Patient Consent for use and Disclosure of Protected Health Information** as explained in the Program Description form. I have received the **Notice of Privacy Practices.**

Parent/ Guardian Signature **Date** **Parent/ Guardian Printed Name**

Patient Signature (Only if 18 or older) **Date** **Patient Printed Name (Only if 18 or older)**

School-Based Health Center Student Information

Please PRINT CLEARLY or it may delay the processing of this form and slow our ability to schedule your child for the necessary care!

STUDENT INFORMATION:

Students Name: _____ **DOB:**_____ **Sex: M** ____ **F**___

Student's Social Security #: _____ **Students Building:** _____

Student's School ID#: _____ **Student E-mail:**_____

PARENT/ GUARDIAN RESPONSIBLE PARTY INFORMATION:

Name: _____ **Date of Birth:** _____ **Soc Sec #:** _____

Address: _____

Email: _____ **Relationship to Student:** _____

Cell Phone (_____**)** _____ **Home/ work Phone: (**_____**)**

Emergency Contact Person: _____

_____ **Emergency Contact Phone (**_____**)**

Parent / Guardian Signature: _____ **Date:**

Relationship: _____

Previous Primary Care Provider/ Office: _____ **Plan to still use: ___Yes ___No**

Address: _____ **Phone (_____) _____**

Do you want information from our visits sent to them: ___Yes ____No

Date of last complete Physical Exam (head to toe): _____

Parent / Guardian Signature: _____ **Date:**

Immunizations up to date: _Yes ___No

Previous Dental Care Provider/ Office: _____

Plan to still use: ___Yes ___No

Phone (_____) _____

Address: _____

Do you want information from our visits sent to them: ___Yes ___No

Date of last complete Dental Exam: _____

Previous Eye Care Provider/ Office: _____

Plan to still use: ___Yes ___No

Phone (_____) _____

Address: _____

Do you want information from our visits sent to them: ___Yes ___No

Date of last complete Eye Exam: _____

Parent / Guardian Signature: _____ Date:

Were they dilated: ___Yes ____No

Preferred Pharmacy: _____

Pharmacy Phone (_____) _____

INSURANCE INFORMATION:

Primary Insurance Name	Policy #	Group #	Effective	Co-Pay	Policy Holder	Relationship
Secondary Insurance Name	Policy #	Group #	Effective	Co-Pay	Policy Holder	Relationship

Parent / Guardian Signature: _____ Date: _____

Student Name: _____ DOB: _____

STASTISTICS REQUIRED FOR GOVERNMENTAL REPORTING PRIMARY CARE AND PRIMARY DENTAL CARE PROVIDERS

Please ☑ the box with the best answer for the questions below:

Race: ☐ White ☐ Black/ African American ☐ American Indian ☐ Asian
☐ Hawaiian ☐ Pacific Island ☐ More than one race ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/ Not Reported

Languages you can speak fluently:
☐ English ☐ Spanish ☐ French ☐ German ☐ Russian ☐ Other_____
Do you speak English fluently? ☐ Yes ☐ No If no, preferred language:_____

Mark ALL that apply: ☐ Visually Impaired ☐ Hearing Impaired ☐ Language Barrier
☐ Veteran ☐ Smoker ☐ Homeless ☐ Migrant Farm Worker

Religion: ☐ Christian ☐ Agnostic ☐ Atheist ☐ Buddhist ☐ Jewish ☐ Hindu
☐ Islamic ☐ Pentecostal ☐ Scientologist ☐ Other

Tax Filing Status: ☐ Return Not Filed ☐ Single ☐ Married ☐ Head of Household
If Head of Household marked, please indicate if ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced
☐ Life Partner ☐ Other _____

Student Status: ☐ Full-time Student ☐ Part-time Student

CONTACT PREFERENCES:

☐ Home ( ) _____ ☐ Day/Work ( ) _____
☐ Cell/ Alternate ( ) _____
☐ E-mail/ Patient Portal: _____

ADVANCED DIRECTIVE:

Do you have a living will? ☐ Yes ☐ No
If yes, at which hospital is it filed? _____

ANY OTHER INFORMATION WE SHOULD BE AWARE OF:

Student Name: _____ DOB: _____

STUDENT HOME, SCHOOL, & HEALTH HISTORY FORM

Please circle yes or no below, and explain any yes answers on the line provided.

HOME HISTORY

Does anyone in the home smoke? YES NO _____

Has your child be a victim of abuse/ bullied? YES NO _____

Has your child seen someone abused? YES NO _____

Do they get enough to eat? YES NO _____

Is there a gun in the home? YES NO _____

What activities / hobbies do they enjoy? _____

SCHOOL HISTORY

Are there any learning problems/ disabilities? YES NO _____

Are they in special classes or have an IEP? YES NO _____

Have they repeated any grade? YES NO _____

Do they get into trouble often at school? YES NO _____

What are their grades? _____

Are they changing from the past? YES NO _____

MEDICAL/ DENTAL/ EYE HISTORY

Do they take any medications currently? YES NO _____

_____

Have they previously taken medications? YES NO _____

_____

Are they allergic to any medications? YES NO _____

_____

Have they ever been pregnant? YES NO # of Pregnancies? ____ # Living Children _____

Ever in hospital overnight? YES NO _____

Any previous surgeries? YES NO _____

Any previous head injuries? YES NO _____

Any developmental delays? YES NO _____

Other Medical Concerns? YES NO _____

Any dental pain? YES NO _____

Do they brush their teeth? Only morning Only night Both morning and night Rarely Never

Do they floss? Only morning Only night Both morning and night Rarely Never

Have they ever had fluoride treatments? YES NO _____

Have they learned the importance?

of primary teeth? YES NO _____

Other Dental Concerns? YES NO _____

Have they had glasses in the past? YES NO _____

Student Name: _____ DOB: _____

If yes, do they still have them and wear them?	YES	NO	_____
Trouble seeing the board at school?	YES	NO	_____
Trouble seeing close work?	YES	NO	_____
Trouble with changing distance to near and back to distance viewing?	YES	NO	_____
Headaches with vision related tasks?	YES	NO	_____
Other Eye Concerns?	YES	NO	_____

Does your child or any family member have or had any of these problems? (Please check ALL that apply)

	Child	Family		Child	Family		Child	Family
Asthma/ Wheezing			Eye trauma			Seizure Disorder		
Allergy/hayfever			Fainting w/ exercise			Sickle Cell		
Allergy/ food			Glaucoma			Sinus issues		
Allergy/ pets			Headaches/ Freq			Sleep apnea		
ADHD/ADD			Hearing Loss/concern			Sleep issues		
Anemia/ blood			Heart Disease			Snoring		
Anaphylactic Rxn			Heart Murmur			Sore Throat/ freq		
Acne			Kidney Dis/ issues			Speech issues		
Alcohol Abuse			High Blood Pressure			Spinal curvature		
Behavior Issues			HIV/ AIDS			Stomach Ache/freq		
Bleeding disorder			Hives			Stroke		
Bowel Movements			Hyperactivity			Suicide Attempt(s)		
Broken bones			Joint problems			Testicle not in sac		
Cancer - type			Lazy Eye			Toothache/ dental		
Cataract			Lead poisoning			Tuberculosis		
Chicken Pox			Learning problems			Twitching eyelid		
Chronic Ear Inf.			Leukemia			Underweight		
Cholesterol High			Light sensitivity			Urinary Tract In		
Concussion			Lumps groin/breast			Vaginal Discharge		
Constipation			Mental illness			Watery Eyes		
Depression			Migraines					
Diabetes			Muscle problems					
Diarrhea			Nervous twitch/tics					
Dizzy/ light headed			Nose bleed					
Dry/ burning eye			Nightmares					
Eczema/ skin infec			Obesity					
Eye strain			Rheumatic fever					

THE FOLLOWING PAGES

ARE FOR YOU TO REVIEW

AND KEEP FOR YOUR

RECORDS

Program Description
School-Based Health Center

Welcome to Primary Health Solutions' School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child without having to take time away from work and minimize the time that your child is out of the learning environment.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, dental care, eye exams, and all associated health care concerns. Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, attempts will be made to contact you as necessary. .
- **The School-Based Health Center does not take the place of your primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with that PCP and a summary of your child's visit at the SBHC will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and can become your child's PCP. If your child is already a patient of any Primary Health Solutions locations, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call **(513) 454-1111**.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Primary Health Solutions sliding fee scale. This information will be kept strictly confidential.

- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at Primary Health Solutions. If your insurance does not cover Primary Health Solutions, you will be responsible for the bill at the appropriate discounted fee based on your household income.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call **(513) 454-1111**. You can also contact the Butler County Job and Family Services Department at (513) 887-5600.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's PCP.
- Primary Health Solutions, the School-Based Health Center and/or the school nurses will share medical information, including immunization records, with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, School-Based Health Center or Primary Health Solutions may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Primary Health Solutions' Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Primary Health Solutions reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Primary Health Solutions at 210 South Second Street, Hamilton, OH, 45011.

With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or Primary Health Solutions may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or Primary Health Solutions restrict how it uses or discloses, my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in Hamilton, Middletown or Fairfield Public Schools. You **may revoke** this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Primary Health Solutions at **(513) 454-1111** or contact your school nurse.

(Rev. 08/17)