Talawanda School District
HEALTH ENROLLMENT PACKET
TRIHEALTH PHYSICIAN PRACTICE OXFORD PEDIATRICS
5141 Morning Sun Road
Oxford, Ohio 45056
513-523-2156

Talawanda School District has partnered with TriHealth Physician Practices Oxford Pediatrics (hereafter "Oxford Pediatrics") to improve health care access for children. Oxford Pediatrics employs pediatric primary care specialists who have special training in meeting the health care needs of children and adolescents. Please contact the office with any questions or concerns.

STUDENT INFORMATION

Today's Date:	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

Student's School:	Student's Grade:	Student's School ID #
☐ Kramer ☐ Middle school ☐ Bogan ☐ High School ☐ Marshall		

If you have a Primary Care Provider, please provide name, address and phone number:

Pharmacy Information: Where would you like your child's prescription sent if necessary:

INVOLMENT IN CARE AND CONSENT FOR HEALTH CARE SERVICES

Parents and guardians are always welcome to attend appointments. My signature acts as acknowledgement that I understand I am responsible for following up with Oxford Pediatrics regarding the health care services and treatment provided, especially when I am unable to attend the appointment. I am also responsible for following up with the provider regarding any questions or concerns I have.

My signature below also provides Oxford Pediatrics consent to treatment the minor child listed above. Treatment may include examination, diagnosis, general medical care, and treatment (including, but not limited to physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by employees, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its subsidiaries (hereinafter "TriHealth").

_____
Parent or Guardian's Signature

_____
Date

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

IMMUNIZATION/VACCINATION CONSENT

Per Center for Disease Control ("CDC") guidelines children should receive the following vaccinations:

Flu Vaccine	Tetanus, diphtheria, pertussis (Tdap))	Human papillomavirus (HPV)
Meningococcal (MENACWY)	Pneumococcal ((PCV13)	Hepatitis B
Hepatitis A	Polio	Varicella (chickenpox)
Measles, mumps, rubella (MMR)		

The recommended vaccine schedule for children is attached, as well as, Vaccination Information Statements ("VIS").

My signature below certifies that I have reviewed the attached VIS's. I am aware of the benefits, risks, and precautions for each of the vaccinations and that certain preexisting health conditions may require notification and discussion with a health care provider prior to administration.

My signature below indicates I have provided a complete, thorough medical history and given Oxford Pediatrics permission to vaccinate my child, if vaccination is deemed appropriate.

_____

Parent or Guardian's Signature

_____

Date

TRANSPORTATION

To receive medical care, Talawanda School District will provide transportation to Oxford Pediatrics

☐ **YES,** I consent for my child to be **TRANSPORTED /ACCOMPANIED** to and from Oxford Pediatrics by a Talawanda designee. I, the parent or guardian of above named student, release Oxford Pediatrics, TriHealth, its Board members, its 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.

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Provider Making the Use or Disclosure: I authorize TriHealth G, LLC d/b/a Oxford Pediatrics (referred to as "Health Care Provider") to release my child's individually identifiable health information as described below.

2. Recipient of the Information: I authorize the Health Care Provider to release the information described in this authorization to the

- **TALAWANDA SCHOOL NURSE**
- **PRIMARY CARE PRACTITIONER (IF ONE IS INDICATED ON THE 1ST PAGE)**

3. Type of Information to be Released: Describe the type of information that you want to be disclosed pursuant to this Authorization—

A. MEDICAL RECORDS: (Check "All Medical Records" or "Other")

☐ **ALL MEDICAL RECORDS WHEN SEEN AS PART OF THE SCHOOL BASED HEALTH PROGRAM; *or***

☐ **OTHER—I only want the following parts of my medical record to be disclosed**:

_____

_____

B. DATES OF TREATMENT: (Check "All dates of Treatment" or "Specific dates of treatment")

☐ **All dates of treatment when my child was seen in the school based health program**

☐ **Specific dates of treatment: I only want records for the following dates of treatment to be disclosed**: _____

Further, I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

4. Your Refusal to Sign this Authorization: The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

5. Purpose for the Use or Disclosure: The purpose for the disclosure is at the patient's request for participation in the Talawanda School Based Health Program.

6. Oral Communications: I understand that this Authorization allows the Health Care Provider (and its employees) to discuss my individually identifiable health information described herein with the recipient of the information.

7. Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

8. Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

9. Expiration: This Authorization will expire upon the earlier of one year after the date below or the date the patient is no longer enrolled in the Talawanda School Based Health Program.

REVOCATION OF AUTHORIZATION

I agree that if at any time, I no longer want to be part of the School Based Health I will immediately notify **Talawanda School District** in writing by sending a letter to the address of **131 W. Chestnut Street, Oxford Ohio 45056.** The revocation will be deemed a revocation of this authorization in its entirety. I understand that if I want to allow for any future authorization for treatment of my child, I will have to complete and sign a new authorization.

By signing below, I am agreeing to the above statements on:

- Transportation
- Authorization for Disclosure Of Protected Health Information
- Revocation of Authorization

Patient/Parent/Guardian Signature:	Print Name:	Date of Signature:

☐ Patient ☐Parent ☐Guardian

PATIENT REGISTRATION/FINANCIAL SECTION

PATIENT INFORMATION				
Last Name:	First Name:	Nickname	Social Security #	Date of Birth:

☑ **Birth Gender:**	☑ **Gender Identify**	☑ **Sexual Orientation:**
☐ Female	☐ Choose not to disclose	☐ Choose not to disclose
☐ Male	☐ Female	☐ Straight, Heterosexual
	☐ Female-to-Male (FTM) Transgender Male	☐ Bisexual
	☐ Genderqueer, neither exclusively Male or Female	☐ Lesbian, Gay, Homosexual
	☐ Male	☐ Don't know
	☐ Male-to-Female (MTF) Transgender Female	☐ Other
	☐ Other	

Patient Billing Address (Responsible Party)	Patient Residence (if different)

☑ **Preferred Language**		☑ **Religion**			☑ **Check all that apply**
☐ English	☐ Spanish	☐ Christian	☐ Jewish	☐ Atheist	☐ Smoker
☐ French	☐ German	☐ Buddhist	☐ Hindu	☐ Agnostic	☐ Hearing Impaired
☐ Napoli	☐ Russian	☐ Islamic	☐ Scientology		☐ Visually Impaired
☐ Other:		Other:			

Can we send notifications to you via?	**Which contact number do you prefer:**
☐ Email	☐ Home Phone:
☐ Phone	☐ Work Phone:
☐ Text	
☐ Voicemail	☐ Cell Phone:
☐ No you cannot send me notifications	

Emergency Contact Name	**Emergency Contact Relationship**	**Emergency Contact Phone #**

EMPLOYMENT INFORMATION OF GUARENTOR		
Employer Name:	Occupation:	Employer Phone Number:

RESPONSIBLE PARTY (Required for patients less than 18 and whenever the guarantor is not the patient					
Last Name:	First Name:	MI	Social Security #:	Date of Birth:	Relationship:

INSURANCE INFORMATION (Please attach a copy of the front and back of card if possible)						
Primary Insurance	Policy #	Group #	Eff Date	Co-pay	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Eff Date	Co-pay	Policy Holder	Relationship
Tertiary Insurance	Policy #	Group #	Eff Date	Co-pay	Policy Holder	Relationship

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

FINANCIAL ASSISTANCE/HOUSEHOLD INCOME

It is the policy of Oxford Pediatrics and TriHealth to offer Financial assistance for those who have no means, or limited means, to pay for their medical services. Discounts will be based on income and family size. Please complete the following information if you would like to determine if you are eligible for financial assistance.

**For the purpose of assistance, family is defined as: a group of two or more people related by birth, marriage, or adoption and residing together, all such people (including related subfamily members) are considered as members of one family.*

Section a: Total combined income for all persons working in the household. **Section B:** How often you get paid. **Section C**: Any additional income received in the household**. Section D:** Total number of people the household supports.

I understand to determine my eligibility for financial assistance, I must provide one of the following to Oxford Pediatrics: prior year W-2, 2 most recent pay stubs, or letter from employer or Form4506-T (if W-2 not filed). If self-employed , the most recent 3 months of income and expenses for the business. I agree to inform Oxford Pediatrics of any changes in circumstances that my affect the patient's eligibility. I understand that any intentional false information provided will be grounds for denial of services to patient. I understand the information must be updated every 12 months.

A: Total Household income before taxes:	**B: Frequency**	**C: Other Income**	**D: Total # of people supported by income:**
$	☐ Hourly ☐ Weekly ☐ Bi Weekly ☐ Monthly ☐ Yearly	$	

DOCUMENTATION OF NO INCOME

If you have reported $0 household income in the section above, please explain how you are meeting your daily needs.

ACKNOWLEDGEMENT AND CONSENT FOR PAYMENT:

Oxford Pediatrics will bill your insurance company for services provided. Oxford Pediatrics DOES NOT accept responsibility for collecting or failing to collect insurance claims and you acknowledge that you are responsible for payment for any services provided and that you will pay any and all charges due and owed to Oxford Pediatrics (including co-pays, and/or deductibles.

Oxford Pediatrics will initiate payments for your claims for benefits. In order to do this, it is necessary for all responsible parties to give us certain rights and permission:

I as a patient or agent of patient hereby assign and transfer all rights of a third party payer benefits for service rendered to me by Oxford Pediatrics and authorize any insurance or third party payments be made directly to Oxford Pediatrics. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug related conditions, psychological conditions and/or HIV related conditions.

By signing below, I am agreeing to the statements above on:

- Acknowledgement And Consent For Payment

Patient/Parent/Guardian Signature:	Print Name:	Date of Signature:

☐ Patient ☐Parent ☐Guardian

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

HIPPA requires that Oxford Pediatrics give you a Notice of Privacy Practice that describes how Oxford Pediatrics will use and disclose your protected health information and explains your privacy rights.

Please answer the following questions so we can contact you in the most efficient way possible:

If you have an answering machine at home, may we leave a message? ☐ Yes ☐ No

May we leave a message at your work for you to call our office? ☐ Yes ☐ No

Is there a person at your home we can leave a message with? ☐ Yes ☐ No

If yes who:

By Signing below, I authorize Oxford Pediatrics to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practice I have received.

Patient/Parent/Guardian Signature:	Print Name:	Date of Signature:

☐ Patient ☐Parent ☐Guardian

☐ Check here if you refuse to sign the acknowledgement of receipt of Notice of Privacy Practice

PATIENT HEALTH HISTORY

Today's Date:	Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

HOME HISTORY	**YES**	**NO**	**COMMENTS**
Does anyone in the home smoke?			
Has your child been a victim of abuse/ bullied?			
Has your child seen someone abused?			
Do they get enough to eat?			
Is there a gun in the home?			
What activities / hobbies do they enjoy?			
SCHOOL HISTORY	**YES**	**NO**	**COMMENTS**
Are there any learning problems/ disabilities?			
Are they in special classes or have an IEP?			
Have they repeated any grade?			
Do they get into trouble often at school?			
Are any of the responses above different from the past?			
What are their grades?			
MEDICAL/DENTAL/EYE HISTORY	**YES**	**NO**	**COMMENTS**
Date of last Exam (head to toe)	Date of Exam:		Provider's Name:
Do they take any medications currently?			
Have they previously taken medications?			
Are they allergic to any medications?			
Have they ever been pregnant?			# of pregnancies # of living children
Ever in the hospital overnight?			
Any previous surgeries?			
Any previous head injuries?			
Any developmental delays?			
Immunizations up to date?			
Other Medical Concerns?			
Date of last dental exam	Date of Exam:		Provider:
Any dental problems (pain)			
Any dental procedures in the past			
Date of last eye exam	Date of Exam:		Provider:
Have they had glasses in the past?			
If yes, do they still have them? Wear them?			
Trouble seeing things close?			
Trouble with changing distance?			
Headaches with vision related tasks?			
Other Eye Concerns?			
Any other information we should be aware of?			

Student's Last Name:	Student's First Name:	M.I.	Student's Date of Birth:

Does student or any family member have or had any of the following problems? (Check box)

PROBLEM	STUDENT	FAMILY	PROBLEM	STUDENT	FAMILY	PROBLEM	STUDENT	FAMILY
Asthma/Wheezing			Eye Trauma			Seizure Disorder		
Allergy/Hay Fever			Fainting w/Exercise			Sickle cell		
Allergy/Food			Glaucoma			Sinus Issues		
Allergy/Pets			Headaches/Freq.			Sleep apnea		
ADHD/ADD			Hearing Loss			Sleep issues		
Anemia/Blood issues			Heart Disease			Snoring		
Anaphylactic reaction			Heart murmur			Sore throat/Freq.		
Acne			Kidney issues			Speech issues		
Alcohol Abuse			High Blood Pressure			Spinal curvature		
Behavioral issues			HIV/AIDS			Stomach ache/Freq.		
Bleeding disorders			Hives			Stroke		
Bowel Movement issues			Hyperactivity			Suicide Attempt(s)		
Broken Bones			Joint Problems			Testicle not in sac		
Cancer			Lazy eye			Toothache/Dental		
Cataract			Lead Poisoning			Tuberculosis		
Chicken Pox			Learning Problems			Twitching eyelid		
Chronic ear infections			Leukemia			Underweight		
Cholesterol high			Light sensitivity			Urinary tract infections		
Concussion			Lumps in groin			Vaginal discharge		
Constipation			Lumps in breast			Watery eyes		
Depression			Migraines			Other:		
Diabetes			Muscle Problems					
Diarrhea			Nervous Tics					
Dizzy/light headed			Nose Bleeds					
Dry/burning eyes			Nightmares					
Eczema/skin issues			Obesity					
Eye Strain			Rheumatic Fever					

☐ By checking this box I am acknowledging that I have reviewed the document and there is no student or family history of the problems listed above.

Patient/Parent/Guardian Signature:	Print Name:	Date of Signature:

☐ Patient ☐Parent ☐Guardian

THE FOLLOWING PAGES ARE FOR YOU TO REVIEW AND KEEP FOR YOUR RECORDS

Talawanda and Oxford Pediatrics care about your child and have partnered to help your child get appropriate, needed healthcare for your child in a School Based Health Program. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, or a vision exam they can have it done at Oxford Pediatrics as part of this program.

HOW THIS PROGRAM WORKS:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- After your child's visit with the provider, attempts will be made to contact you as necessary.
- **This program 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 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 Oxford Pediatrics, you still have to sign this consent to be a part of the School-Based Health Program.

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 and transfer of treatment records.
- After school hours, in case of emergency call 911 or go to the nearest emergency room.

THE HEALTH SERVICES WE MAY PROVIDE INCLUDE:

- Ill visits (for example, for sore throat, rash, cold symptoms, and earache) 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 asthma, hypertension, diabetes, and high cholesterol.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided in our office.

REGARDING PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill.
- 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 determine if you qualify for financial assistance (reduced or waived fees). 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 Oxford Pediatrics. If your insurance does not cover Oxford Pediatrics, you will be responsible for the bill at the appropriate out of network fees.
- If you need assistance applying for Medicaid contact the Butler County Job and Family Services Department at (513) 887-5600.

Regarding the SHARING OF HEALTH INFORMATION

- School Based Health Program 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 Oxford Pediatrics to your child's PCP.
- Oxford Pediatrics and 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 Program. 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 you 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, Oxford Pediatrics may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Oxford Pediatrics' 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. Oxford Pediatrics reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Oxford Pediatrics at 5141 Morning Sun Road, Oxford, Ohio 45056.
- With my consent, Oxford Pediatrics 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, Oxford Pediatrics 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 Oxford Pediatrics 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 use 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, Oxford Pediatrics may decline to provide treatment to me.

*Please note that the School Based Health Program is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School Based Health Program or not. **This consent will remain in effect until your child is no longer enrolled in Talawanda School District.** You **may revoke** this consent for treatment at any time by requesting to Talawanda and Oxford Pediatrics , in writing, to have your child removed from School-Based Health Program.

The School-Based Health Program 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, please call Oxford Pediatrics at **(513) 523-2156** or contact your school nurse.

Pages 14: Meet the Oxford Pediatric Care Team

Pages 15-18: Recommended Children between birth – 18 years of age immunization tables from Center for Disease Control and Prevention

Pages 19--33: Center for Disease Control and Prevention's Vaccine Information Statements

- Child's first vaccines which include:
    - Diphtheria, Tetanus, Purtussis (DTaP)
    - Haemophilus Influenza Type B (Hib)
    - Hepatitis B
    - Polio
    - Pneumococcal Disease (PCV13)
- Hepatitis A
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal ACWY
- Varicella (Chickenpox)
- Flu Vaccine (inactivated)

Meet your Care Team

The Oxford Pediatrics team has been caring for infants, children and adolescents in the Oxford area since 1985. Their education and experience has made them experts in Pediatric Health Care. Their goal is to serve children and families, providing care that allows for optimal health.

James Davis MD
Medical School: University of Cincinnati College of Medicine
Board Certification: American Board of Pediatrics

Sofia Gofman MD
Medical School: Second Moscow Medical Institute
Board Certification: American Board of Pediatrics

Jill Mock, MSN, CPNP
Bachelors of Science in Nursing: University of Michigan
Masters of Science in Nursing: University of Cincinnati
Board Certified Pediatric Nurse Practitioner

Sandy Simpson, BSN, CPNP
Bachelors of Science in Nursing: Capital University
Board Certified Pediatric Nurse Practitioner