NAME OF HEALTH CENTER

Dear Parent(s) or Guardian:

Great News!!! _____ Medical Center, in collaboration with _____, is sponsoring a school-based health center located at _____. The health center was created to remove all barriers to your child's healthcare (transportation, inability to leave work for medical appointments, etc.) while providing quality healthcare at school. Our ultimate goal is for every student to receive the best education possible by ensuring good health and improved attendance.

The_____ school-based health center will be staffed by medical (nurse practitioner, doctors) and mental health personnel from _____ Medical Center and _____. The health center will provide services similar to what you would receive in a doctor's office. They include:

- Treatment for minor illnesses (colds, allergies, strep throat, ear infections, pink eye, skin rashes, etc.) or injuries (scrapes, strains and cuts),
- Treatment for chronic illnesses (asthma, sickle cell, diabetes, etc.)
- Treatment/Counseling for behavioral health conditions (Attention Deficit Disorder, depression, etc.)
- Well Child Checks (including immunizations, hearing and vision screenings).
- Routine School and Sports Physicals
- Lab tests (including COVID testing)
- Referrals to subspecialists (neurologist, surgery, orthopedics, ophthalmologist, etc.)
- Health Education

The health center accepts all forms of insurance plans, private and public (Medicaid and PeachCare). If you do not have Medicaid or any type of insurance, please give us a call. You may be eligible for our Sliding Scale program based on household income. **No child will be denied services based on their inability to pay.**

****Finally, your child(ren) cannot be seen without a signed consent form. If you are not able to be present when your child is seen, you will be notified before and after your child's visit and, if possible, will be able to participate in the visit by internet or phone. No medical decision will be made without your involvement. The School Based Health Center will not infringe upon the parent-child relationship in the process.**

Please fill out the consent form and return it today.

We look forward to providing these valuable services for all students. If you have any questions, please do not hesitate to contact us at - _____.

Thanks,
School-Based Health Center Team

CONSENT FORM

In order for your child to receive services at the _____ Elementary School-Based Health Center, this consent form must be completed and proper documentation of insurance obtained. Please complete all sides of this consent form.

I hereby voluntarily give my consent for _____ to receive the health
Name of Child
services at the _____. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical and behavioral health evaluation and management of my child's health care. Services provided by the health center include but are not limited to the management of acute and chronic illnesses, well-child checks, sports physicals, immunizations, mental health counseling, dental care, and referrals to sub-specialists.

I authorize the release of information from my son or daughter's medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care, including referrals and/or emergency services.

I authorize the sharing of information from my son or daughter's health record to and from the school-based health center staff, school psychologist, school social worker, school nurse, and/or school counselors whenever necessary to coordinate their health care.

I authorize the health center to release information regarding treatment to third-party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale**. No patients will be denied services because of inability to pay.**

I understand that my signing this consent allows the physician and professional clinic staff of the _____Health Center to provide health services. I authorize periodic dental examinations for my child, which may include photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child's dental health. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at _____.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

_____ _____

Name of Parent or Legal Guardian **(PLEASE PRINT)** Name of Patient **(PLEASE PRINT)**

_____ _____

Signature of Parent/Legal Guardian Relationship to Patient

_____

Date

Please complete all information on the **FRONT AND BACK** of this permission form. You must **COMPLETE USING INK** then sign and date it in order for your child to receive services from the Health Clinic. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Date_____Patient's Name_____ _____ _____
Last First Middle

Address_____Apt.#_____City_____State_____Zip_____

(Office Use Only) Address update_____

How long at present address?____Years____Months **** How long at previous address?_____Years_____Months

Is present housing: ____Permanent___ Temporary ___ Shelter ___ Institution ___None ____Unstable ____Foster Care ____Other

Who lives with student: Please list everyone who lives in home including yourself:

NAME	RELATIONSHIP	AGE

Home Phone#_____Mother's Work Phone#_____Father's Work Phone# _____ Pager #:_____

(Office Use Only) Additional #'s: Date/Name_____ _____

Emergency Name & Number_____ Relationship to Patient_____

Birth Date_____ Birth Country: ____USA____Other **** Primary Language:____English____Other

Social Security Number_____ Sex (circle one): Male Female

Race: ___Black ____White ____ Hispanic ____ Asian Other: specify_____

School_____ Grade_____ Remedial/Special Education ____Yes ___No

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WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE:

PLEASE PROVIDE PROOF OF INSURANCE OR YOU MAY BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. PLEASE LIST ALL INSURANCE COVERAGE CHILD IS ELIGIBLE FOR.

___Medicaid#_____

(Office Use Only) Additional #'s: Date/Name_____ _____

___Private: Company Name_____Policy #_____Group #_____

Address_____

___No Insurance

(You may be eligible for free insurance. Would you be interested in someone contacting you regarding this "free" insurance? ___Y ___N)

Where do you take your child for Primary care/Routine care and Acute care/Emergency/Sick visits? In the columns below check the ones that apply and fill in names, addresses and phone numbers.

	PRIVATE DOCTOR OR CLINIC	HOSPITAL OUTPATIENT CLINIC	NAME / ADDRESS/ PHONE NUMBER
PRIMARY CARE/ROUTINE CARE			
ACUTE CARE EMERGENCY SICK VISITS			

Please write the name & **phone #** of a nearby pharmacy.

Pharmacy/Phone#_____

Has your child seen a doctor in the last year?_____Yes ____No
If yes, how many time? Circle 1 time 2 times 3 times 4 or more times

Where?_____

Why?_____

Has your child used a Hospital Emergency Room in the last year?____Yes ____No
If yes, how many times? Circle: 1 time 2 times 3 times 4 or more times

Where?_____

Why?_____

Was your child in the hospital over night in the last year? ____Yes ____No

Where?_____

Why?_____How Long_____

Student's Regular Dentist_____Date of Last Visit_____

Hospitalizations?____Yes____No, If yes where/ reason/date_____

Physical Handicap?____Yes____No, If yes type_____

Health Problems Under Treatment?____Yes____No, If yes explain_____

Specify where receiving treatment_____

Daily medications and dosages____Yes____No, If yes explain_____

Do you or anyone in the home:

	WHO	**RELATIONSHIP TO** PATIENT
SMOKE		
DRINK ALCOHOL		
USE DRUGS		
CHEW TOBACCO		

Family History: (Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)
Please specify who has or had any disease listed below by using abbreviations above.

	WHO		**WHO**
Asthma	_____	Heart Trouble	_____
Allergies	_____	High Blood Pressure	_____
Birth Defects	_____	Kidney/Bladder Problems	_____
Blood Disorders/Anemia	_____	Lung Diseases	_____
Cancer	_____	Tuberculosis	_____
Tumors	_____	Seizures	_____
Cystic Fibrosis	_____	Mental Retardation/Illness	_____
Diabetes (before 40)	_____	Muscle Disease/Weakness	_____
Early Childhood Death	_____	Death Under Age 50	_____
Ear/Eye Disorders	_____	There is no family history of the above diseases	_____

CHILD'S MEDICAL HISTORY

NAME _____ **BIRTHDATE**_____ **TEACHER**_____

ILLNESS HISTORY

Allergies	__Yes__No
Allergic to drugs	__Yes__No
Anemia	__Yes__No
Asthma	__Yes__No
Other Respiratory Problems	__Yes__No
Stomach Ulcers	__Yes__No
Abdominal Pain	__Yes__No
Constipation/Diarrhea	__Yes__No
Serious Digestive Problems	__Yes__No
Chicken Pox Age____	__Yes__No
Ear Problem	__Yes__No
Ear Infections	__Yes__No
Hearing Aid	__Yes__No
Eye Problem	__Yes__No
Wears Glasses	__Yes__No
Physical/Sexual Abuse	__Yes__No
Fainting Spells/Knocked Out	__Yes__No
Frequent Sore Throat	__Yes__No
Headaches	__Yes__No
Heart Murmur	__Yes__No
Heart Problems	__Yes__No
High Blood Pressure	__Yes__No
Thyroid Problems	__Yes__No
Diabetes	__Yes__No
Hepatitis	__Yes__No
Injuries (major)	__Yes__No
Musculo-Skeletal Problems	__Yes__No
Brokens Bones	__Yes__No
Problems Walking	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No
Frequent Colds	__Yes__No
Lung Problems	__Yes__No
Meningitis	__Yes__No
Menstration Started Age____	__Yes__No
Menstrual Problems	__Yes__No
Premature Birth Weight_____	__Yes__No
Obese	__Yes__No
Skin Rashes	__Yes__No
Serious Acne	__Yes__No
Sickle Cell Disease	__Yes__No
Sickle Cell Trait	_Yes_No
Other Blood Disorders	_Yes_No
Seizures/Epilepsy	_Yes_No
Speech Problem	_Yes_No
Tuberculosis	_Yes_No
Cancer	_Yes_No
Other_____	__Yes__No

BEHAVIOR HEALTH

Eating Problems	__Yes__No

BEHAVIOR HEALTH (Cont'd)

Nightmares	__Yes__No
Bedwetting	__Yes__No
Discipline Problems	__Yes__No
Overactive/Hyperactive	__Yes__No
Shy	__Yes__No
Sleeping Problems	__Yes__No
Slow Development	__Yes__No
Learning Disability	__Yes__No
Smoker	__Yes__No
Alcohol	__Yes__No
Inhalants	__Yes__No
Other Drugs _____	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	_Yes__No
Other_____	__Yes__No

Explain any behavior or mental problems noted _____

_____

_____

PLEASE LIST ANY PRESENT CONCERNS:

_____

_____

_____

***Explain any illnesses marked yes:

_____

_____

_____

_____

DENTAL

Dental Problems	__Yes__No
Pregnant	__Yes__No
AIDS/HIV	__Yes__No
Rheutmatic Fever	__Yes__No
Hemophilia	__Yes__No
Underweight	__Yes__No

When was your child's last dental visit?

_____

How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? _Yes _No

Has your child had any injury to the teeth or jaws? __Yes __No

Does your child have a finger or thumb sucking habit?

Generally speaking, what has been your child's experience with a dentist? __Good __Bad __Very Bad

Thumb Sucking __Yes__No __No experience (the child's first visit)

Revised 12/12/2022