SCHOOL BASED HEALTH CENTER ENROLLMENT PACKET

Hello Parents!

We welcome you and your child to be part of our School Based Health Center. It offers students and faculty access to primary care services. Boston Mountain Rural Health Center (BMRHC) is a Federally Qualified Health Center with over twelve service locations. Parents/Guardians are always welcome at appointments, but are not required to be present as long as THIS PACKET IS FULLY COMPLETED and RETURNED.

How the School Based Health Center Works: Once the student's completed consent and history are received (which are enclosed in this packet), we can begin caring for your child for approved services. We will attempt to notify you of your child's appointment and contact you by phone providing information on his/her visit. If the parent/guardian has signed consents and is not reachable via phone to discuss the appointment, BMRHC will provide a care visit summary to send home to the parent regarding the child's visit.

Already a patient at BMRHC: If you are already a patient of BMRHC we ask that you still complete this packet because some of the packet information varies from our standard patient packet.

This packet includes:

- ❑ About our School-Based Health Center (Parent/Guardian to Keep)
- ❑ School Based Health Center Enrollment Form (will need to be returned to school)
- ❑ Patient Information Form (will need to be returned to school)
- ❑ Consent To Treat (will need to be returned to school)
- ❑ HIPAA Privacy Information (will need to be returned to school)
- ❑ Notice of Privacy Practices-(available online and in the clinic, Parent/Guardian to Keep)
- ❑ Health History 2 pages (will need to be returned to school)

PLEASE RETURN COMPLETED PACKET TO THE SCHOOL NO LATER THAN, October 1st! BMRHC will give away a $100 GIFT CARD to 3 lucky students that return completed forms. We will also award 3 lucky classrooms with a PIZZA party for the classroom with the most returned BMRHC packets.

Parent/Guardian Signature: ____ **Date:** ________________

SCHOOL BASED HEALTH CENTER ENROLLMENT FORM

School District:_____________________________**Campus:**________________________

Grade:__________ **Child's T-Shirt Size:**_______**Graduation Year**:_____________

Student's Name: First________________ **M.**____________ **Last**________________________

- **YES,** I would like for my child to receive medical care at the Boston Mountain Rural Health Center School Based Clinic. **If marking yes, Please continue to complete the remainder of this packet.** Services could include treatment for illness or injury, including over the counter medications or necessary prescriptions, well child exams,telehealth appointments, immunizations and emergency services as needed. Please list the best contact number below: :

  Parent/Guardian:_______________________________ Ph#_______________________

- **NO**, I do not wish for my child to receive medical care at Boston Mountain Rural Health Center School Based Clinic. **If signing no, you do not have to complete the remainder of this packet. If your child has emergent needs at the school, care will be provided regardless of the selection on the form.**

** **Please check only one box below which best fits your needs:**

My child regularly goes to another doctor or clinic for health care. I would like the School-Based Health Center to work with my child's doctor/clinic to keep my child healthy. I give my permission to the School-Based Health Center personnel to release medical records of all treatable visits to the health care provider listed: ______________________________

I would like to change my child's primary care provider to Boston Mountain.

My child does not have a regular doctor or clinic. I would like the School-Based Health Center to provide health care as necessary to keep my child healthy.

PATIENT INFORMATION FORM

Student Information: ❑ No Change from Previous Year

Parent/Guardian Signature: _____________________________________ **Date:** ______________

Student Name:______________________________
DOB:__________________
Gender: Male, Female
Social Security Num:___________________
Address:____________________________
City:_________________ State: _______
Zip: ________________
Home Phone: ________________________
Primary Language: ___________________
Race:______________________
Ethnicity: (circle one) Hispanic Non-Hispanic

Emergency Contact (other than parent)
Name:_______________________________
Phone #:_____________________________
Relationship to Student:_____________________________

Parent/Guardian Contact Information:
Parent/Guardian:______________________
Parent/Guardian DOB:________________
Parent/Guardian SS#:_________________________________
Address:____________________________
City:____________________State:______
Zip:_______________
Contact #: ___________________

Income Range for Household (*please provide best estimate, exact amounts not required*) or circle ‘choose not to disclose’:
$__________________________________
Number In Household: _______________

Pharmacy Name/Location:
____

Health Insurance Information:
Insurance Name:
____
Policy Holder’s Name:________________________________
Policy #______________________________
Telephone # from Insurance Card:________________________________

Group # (if any): _____________________

- If you don’t have health insurance or have billing questions, please contact the School Based Clinic at the number provided with this packet. If there are any changes to insurance after this form is completed, please contact the clinic to update.

_____ Please mark if your child does not have insurance coverage. BMRHC will not deny child care due to inability to pay.

CONSENT TO TREAT

BMRHC requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will

Parent/Guardian Signature: _____________________________________ **Date:** _______________

not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment. **BMRHC also realizes you may have family members or significant people whom you may wish your provider speak with regarding your child's healthcare information. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act.**
The person(s) listed here is/are authorized by me to give consent in person for medical treatment and for the School Based Health Center to contact about appointment outcomes and other information pertaining to my child. This is in effect until revoked in writing by me. This person may also sign any necessary consents or acknowledgements on my behalf, including responsibility for payment (attempts should be made to contact parent or legal guardian for vaccine administration).

Name: ________________________ **Relationship to Student:**_______________**Ph#:**_____________

Name: ________________________ **Relationship to Student:**_______________**Ph#:**_____________

Name: ________________________ **Relationship to Student:**_______________**Ph#:**_____________

I, ____________________(parent/guardian) grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits. ______________________________________
(Name of Child's School)

As with other health related matters, health information cannot be released without consent.
I, ____________________(parent/guardian), therefore also hereby authorize BMRHC to release sports physical results to my child's school**.**

<u>Please read and sign the consent below.</u>
I give consent for my child to receive health care services provided by the staff at the School-Based Health Center. Services could include treatment for illness or injury, including over the counter medications or necessary prescriptions, well child exams, appropriate immunizations, telehealth appointments for medical and behavioral health, and appropriate behavioral evaluations-- unless emergency services are needed. I understand that every effort will be made to contact me prior to any treatment that requires parental consent I WILL NOTIFY THE SCHOOL-BASED HEALTH CENTER IN WRITING IF I WISH TO REMOVE MY CHILD FROM THE HEALTH PROGRAM. In order to provide optimal health care to your child, I understand that it is necessary that the school nurse and designated school personnel be involved in my child's care, including facilitating visits with the School-Based Health Center provider.

HIPAA PRIVACY

Parent/Guardian Signature: ______________________________________ **Date:** _______________

Boston Mountain is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization. Please understand that this may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

Boston Mountain participates in programs such as the State Health Alliance for Records Exchange (SHARE), CommonWell and CareQuality to share and receive your health information statewide among your doctors, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs. If you wish to opt-out, you must ask your health care provider for and complete an Opt-Out Form. You can also opt-out for your minor child (under the age of 18) using the same process.

❑ I have received a copy of Boston Mountain's Notice of Privacy Practices.

❑ I authorize Boston Mountain to bill my insurance for services rendered.

STUDENT HEALTH HISTORY

Child's Name: ______________________________________ DOB: __________________

Parent/Guardian Signature: ______________________________________ Date: _______________

Are there any problems that concern you about your child?
____
____
____

Does your child have any **allergies** (food, medication, environmental)? Please list the allergy and the reaction:
____
____
____

Current medications (include vitamins/fluoride/supplements):
1.____________________Prescribed by:____________________
2.____________________Prescribed by:____________________
3.____________________Prescribed by:____________________

Date of last physical examination: ____________ By Whom: ______________

Date of last dental examination: ____________ By Whom: ______________

Date of last eye examination: ____________ By Whom:______________

List hospitalizations, illnesses, accidents, broken bones, surgeries, etc. Please include Date and Child's age and explain:____
____
____
____

Please list any specialist that your child currently sees:
1. ______________________ Location:______________
2. ______________________ Location:______________
3. ______________________ Location: ______________

Health History Continued:
Personal History (Patient) **Date:** ____________
Name: ______________________ Date of Birth____/____/______(mm/dd/yyyy)
Age____________

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							

Parent/Guardian Signature: ______________________ **Date:** ____________

BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

Allergies							
Alzheimer’s							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

Parent/Guardian Signature: ____ **Date:** ________________