CHOTA COMMUNITY HEALTH SERVICES - SCHOOL-BASED HEALTH CLINIC

STUDENT Health History Annual Update 2015-2016

Student's Name: _____ **Date of Birth:** _____ **Phone Number:**_____ **Grade:**____

Primary Care Doctor: _____ **Dr's Phone Number:**_____

Pharmacy:_____ **Pharmacy Location:**_____ **Pharmacy Phone Number:**_____

Student's Insurance: Private: BCBS Cigna Humana Other: _____ TennCare: Select Blue Care United Health Care Amerigroup

Student's Medical History

ADD/ADHD	No	Yes	Heart Disease	No	Yes
Asthma (if yes, see Asthma below)	No	Yes	Kidney/Renal Disease	No	Yes
Bladder/Urinary Problems	No	Yes	Nosebleeds	No	Yes
Blood Disorder	No	Yes	Pneumonia	No	Yes
Bowel Problems/Constipation	No	Yes	Premature Birth	No	Yes
Cancer/Leukemia	No	Yes	Spine Disorders	No	Yes
Depression/Anxiety	No	Yes	Seizures	No	Yes
Diabetes Mellitus	No	Yes	Sickle Cell	No	Yes
Earaches/Ear Infections	No	Yes	Stomach Aches	No	Yes
Eczema	No	Yes	Wears Glasses or Contacts	No	Yes
Frequent Infections	No	Yes	Wears Hearing Aid	No	Yes
Chronic Headaches	No	Yes	Weight Issues	No	Yes
Migraines	No	Yes	Other_____		

Current Medications:

Does your child take any medications? No Yes: If yes, please list name and dose of medication (Ex:Concerta 18 mg once a day) _____

Allergies:

Does your child have allergies?	No	Yes	Yes (if yes, please list allergies below)
Food Allergies:	No	Yes	_____
Medication Allergies:	No	Yes	_____
Animals or insects:	No	Yes	_____
Do the Allergies Require Epi Pen?	No	Yes	If yes, what Dr. has prescribed the Epi-pen_____

Asthma Information: Date of last asthma attack _____

Does your child have an inhaler?	No	Yes	Type of Inhaler: _____
Will your child bring inhaler to school?	No	Yes	
Does child use a nebulizer at home?	No	Yes	

Surgeries/Hospitalizations:

Has your child stayed overnight in the hospital?	No	Yes	If yes, describe incident:_____ Date_____
Has your child had a serious injury?	No	Yes	Location of injury?_____Date_____
Has your child had surgery?	No	Yes	If yes, what surgeries?_____Date_____

Family History

Have any Blood Relatives of your child had the following problems? (Mother, Father, Brothers, Sisters, Grandparents) (Please check all that apply, note who in family has this condition on the line beside the condition.)

□ Anemia _____	□ AIDS _____	□ High Blood Pressure_____	□ Sickle Cell_____
□ Diabetes_____	□ High Cholesterol _____	□ Asthma _____	□ Drugs_____
□ Headaches/Migraine _____	□ Muscle or Joint Problems____	□ Stroke_____	□ Tuberculosis _____
□ Sudden Infant Death_____	□ Arthritis/Birth Defect _____	□ Alcoholism_____	□ Seizures _____
□ Early Deafness_____	□ Cancer _____	□ Heart Disease_____	□ Cystic Fibrosis _____

Social History

Exposed to cigarette smoke at home? Yes No Custody papers on file? Yes No

Would you like information on our behavioral health program including individual and family counseling? Yes No

X_____ _____ _____

Signature of Parent/Guardian **Parent / Guardian PRINTED Name** **Date**

EMERGENCY CONTACT: (1)Name:_____ Phone_____ (2) Name:_____ Phone_____

Please note that we need an updated over-the-counter medication permission form each school year, continue to next page 2/2015

Chota
COMMUNITY HEALTH SERVICES

School-Based Health Clinic

Healthy Students Make Better Learners

Did you know that our school-based clinics have Nurse Practitioners available at many of our schools at least 1 time per week? And, if there is not a Nurse Practitioner at your child's school we may be able to use Telemedicine to access the provider from your school (for limited acute illnesses)!

We are a **convenient source** of **quality health care** staffed by Nurse Practitioners and Licensed Behavioral Health Counselors that work in collaboration with your child's doctor and the school nurse.

Your child can receive medical treatment and/or behavioral health counseling right at school! There is no need to take time off from work to take your child to the doctor and travel to and from school, home and a doctor's office. Of course, certain illnesses cannot be cared for at school.

Services:

- **Over The Counter Medications**
- **Treatment for Minor Illness / Injuries by a Nurse Practitioner**
- **Chronic Illness Management**
- **Health Assessments**
  - **Well-Child Exam**
  - **Sports Physicals**
- **Routine lab /diagnostic testing**
- **Immunizations**
- **Developmental Screenings**
- **Behavioral Health Services**
- **Transportation to the Monroe County Dental Clinic for Dental Needs**
- **On-Site Optometrist for vision exam and glasses**

Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report on the visit may be shared with your child's primary doctor at your request.

Cost: Not all school-based clinic services are billable. However, federal and state regulations require all providers, including Chota Community Health Services (CCHS), to bill all patients for School Based Health Center program services such as those provided in a doctor's office. If your child has health insurance, we will bill the insurance company for health services and follow the billing requirements associated with your plan. Depending on your insurance plan, you may receive a bill from CCHS for co-pays and/or deductibles. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their family size and income. All patients are eligible to apply for the sliding fee program even if they have insurance. Finally, the cost associated with lab services will be billed to your insurance. Bills for these tests will come directly from the lab company.

Enrollment: Any student enrolled in the Monroe County Public Schools is eligible to receive services. To enroll your child, complete the attached Enrollment Form including use of Over-The-Counter Medications, Release of Information and return them to your school nurse. If your health information needs updated, or if you have any questions about the program, please contact your school nurse.

Chota
COMMUNITY HEALTH SERVICES

Student's Name:_____ Birthdate:_____ Grade:_____

☐ **I AM NOT INTERESTED IN ENROLLING IN THE SCHOOL-BASED HEALTH CLINIC. I UNDERSTAND THAT MY CHILD WILL ONLY BE ABLE TO RECEIVE EMERGENCY FIRST AID SERVICES AND NURSING ASSESSMENT FOR ILLNESS. MY CHILD WILL NOT BE ELIGIBLE FOR ANY OVER-THE-COUNTER MEDICATIONS PROVIDED BY CHOTA COMMUNITY HEALTH SERVICES.**

If you have elected not to enroll in the School-Based Health Clinic services, you have completed your school health packet. Thank You!

I AM ENROLLING IN THE SCHOOL-BASED HEALTH CLINIC, INCLUDING ACCESS TO OVER-THE-COUNTER MEDICATIONS, AND I AM COMPLETING THE ENROLLMENT PACKET BELOW.
RETURN COMPLETED PACKET *FILLED OUT IN INK (no pencil please)!*

Over-the-Counter Medication
for students enrolled in the school-based clinic

These medications **may** be available for your child through our school-based clinic if he/she is enrolled. **These medications are provided at no charge to you or your insurance company.** You may give permission for the SCHOOL NURSE, if available, to administer these medications to your child if a nursing assessment determines the need and your child meets the nursing guidelines (standing orders).

Please mark one:
- ☐ **I do not want this service for my child.**
- ☐ **All** medication listed below may be given by the school nurse.
- ☐ **Only** the medication marked below may be given by the school nurse.
- ☐ **Please call me** prior to administering any over-the-counter medications.

☐ Tylenol / Acetaminophen	☐ Hydrocortisone Cream 1%	☐ Robitussin DM / Guiafenisin	☐ Antibiotic Ointment
☐ Benadryl / Diphenhydramine	☐ Antacid Tablets or Liquid	☐ Ibuprofen	☐ Benadryl Cream 1%
☐ Saline Eye Drops / Saline Nasal Solution	☐ Topical Anesthetic for Gums (Anbesol / Orajel)	☐ Burn Cream / Gel / Spray Lidocaine HCL 2%	☐ Aloe Vera Lotion (minor sun burns)
☐ Sting Kill / Benzocaine	☐ Calamine Lotion/Spray (Caladryl)	☐ Throat Lozenges	☐ Cough Drops

X_____ _____ _____

Signature of Parent/Guardian **Relationship to Patient** **Date**

Student's Name:_____ **Birthdate:**_____ **Homeroom Teacher:**_____ **Grade**_____

Chota Community Health Services - School-Based Health Clinic

STUDENT'S NAME:_____ **Date of Birth:**_____

Confidentiality between the student, parents and the health clinic is assured. The staff will make every effort to contact you prior to a billable healthcare visit. However, if there are times we are unable to contact you, you may give consent for the following services to be performed by the Chota Community Health Services health care provider, generally a Nurse Practitioner or a Physician Assistant under the direction of a Medical Doctor if you so choose.

Check the box next to the services to which you give consent.

If the School-Based Health Center personnel are unable to contact me, or my designee listed below, the following services may be provided if determined necessary:

☐ Acute Illness such as but not limited to: strep throat, sinus infections, pink eye, ear infections, urinary tract infections, and rashes.

☐ Emergency services such as but not limited to: nebulizer treatments for asthma, Benadryl or epi-pen administration for a severe allergic reaction, oxygen administration for difficulty breathing.

☐ My child has not had a physical exam within the last year. If time allows, I would like for my child to have a comprehensive physical exam during the school year. Date of Last Well Child Exam_____
Name of medical provider for last exam_____

☐ I **do not** want my child seen for a billable office visit unless I, or the persons I have designated below, are contacted.

Medical Release of Information

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

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

☐ My child has a doctor they see regularly. Please keep my doctor informed of any health issues that will ensure continuation of care.

☐ My child has a doctor/provider they see at Chota.

I authorize the release of all medical records or other information regarding school-based clinic office visits that may be important to my child's doctor be released to:
Medical Provider's Name:_____Phone:_____Address: _____ City:_____ State:__

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in accord with this consent. In any event, this consent will expire one year from the date signed by the patient or legally authorized agent.

I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact. The following persons may act as my designee to give or receive medical information and consent for treatment of my child if I am unable to be contacted:

NAME:_____	RELATIONSHIP:_____	PHONE:_____
NAME:_____	RELATIONSHIP:_____	PHONE:_____
NAME:_____	RELATIONSHIP:_____	PHONE:_____
NAME:_____	RELATIONSHIP:_____	PHONE:_____

I, the parent/guardian of the above noted student, give consent for my child to receive services through the School-Based Health Clinic. I understand that if guardianship changes a new consent must be signed by the legal guardian.

X_____ _____ _____

Signature of Parent/Guardian | Parent / Guardian PRINTED Name | Date

Chota Community Health Services - School-Based Health Clinic

Patient Registration

Patient Information

Student's Name: _____ Date of Birth: _____ Sex: M F
First Middle Last (Please Circle)

Mailing Address: _____ City: _____

State: _____ Zip: _____ Social Security #: _____

School: _____ Grade: _____

Race: (Please Mark One) ○ White ○ Black or African American ○ Hispanic ○ Asian ○ More Than 1 Race

○ American Indian / Alaska Native ○ Native Hiwaiian or Other Pacific Islander ○ Other: Specify_____

Parent/Guardian Information

Parent/Guardian's Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Martial Status: (Please Circle One) Married Single Divorced Widowed Other

Parent/Guardian Employer: _____ Phone: _____

Insurance Information

Name of Insurance Company: _____

Group# _____ Member ID or Policy# _____ Co-Pay: $_____

Parent/Guardian Name: _____ Parent/Guardian SS#: _____
(Person Who Holds Insurance Policy) (Social Security # of Policy Holder)

Policy Holder's Date of Birth: _____ Relationship to Child: _____

If you do not have insurance please check here: ☐No Insurance

- **Sliding fee scale is available, ask your school nurse for more information**

Secondary Insurance Information

Name of Insurance Company: _____

Group# _____ Member ID or Policy# _____ Co-Pay: $_____

Parent/Guardian Name: _____ Parent/Guardian SS#: _____
(Person Who Holds Insurance Policy) (Social Security # of Policy Holder)

Policy Holder's Date of Birth: _____ Relationship to Child: _____

X_____ _____ _____ _____
Signature of Parent/Guardian Parent/Guardian PRINTED Name Date Phone Number

We contact parents/guardians prior to all billable visits.

No billable services will be provided without your permission.