COPLIN HEALTH SYSTEMS

School Based Health Enrollment Form

STUDENT INFORMATION *

Student Name: _____ Student SS #: _____

Address- City: _____ Pharmacy: _____

State/Zip: _____ Email: _____ School: _____

Phone: _____ Cell: _____ Grade: _____ Date of Birth: _____

Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:* _____

PARENT / GUARDIAN INFORMATION

Father: _____ (email) _____

Phone (H)_____ (W)_____ (C) _____

Mother: _____Maiden Name:_____ (email) _____

Phone (H)_____ (W)_____ (C) _____

Guardian: _____(email) _____

Phone (H)_____ (W)_____ (C) _____

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs and HIV / AIDS information).

Name: _____ Relationship: _____May we leave a message? __ Y __N

Phone: (Home) _____ (Work) _____ (Cell) _____

Health Information *(Additional health, family & developmental history may be collected if seen at the clinic.)*

1. Doctor's name: _____ Date of last well child exam:_____
2. If your child has not seen a doctor within the last year, would you like your child to have a well child exam at our wellness center? **Yes or No**
3. If we need to call in a prescription, which pharmacy would you like us to call? _____

CURRENT MEDICATIONS

Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

ALLERGIES

Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:

Does the child have an order for and carry any of the follow: (Check all that apply)

_____ Epi Pen _____ Insulin _____ Glucagon

Parent/Guardian Initials: _____

MEDICAL HISTORY List chronic or intermittent disease or health problem(s). Ex: Diabetes, Asthma, High Blood Pressure

_____

_____

SURGERIES List the type and date of the operation (example: tonsils – September 2010)

_____

SERIOUS INJURY OR ACCIDENTS List type of accident and resulting injury and the date (example: broken right leg, 10/08)

_____

Portable Dental Unit

The portable dental unit visits schools twice a year (fall and spring) for dental exams, fluoride treatments, cleaning and sealants. **Please note if your child has an appointment and the forms are not signed and returned for each dental visit, the appointment will be cancelled. If your child is going to another dentist and does not need these services, please mark "no" below**.

Services utilized through the Portable Dental Unit will be billed to your insurance. You will NOT be responsible for any portion of the bill not paid by your insurance. If you do not have coverage, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of the enrollment and consent form.

If your child already has a dentist, he/she does not qualify for this program. Your insurance will not cover the fees of both your regular dentist *and* this program.

Name of Current Dentist:_____ Date of last dental exam: _____

If your child has not seen a dentist in the last year, would you like your child to have a dental cleaning at our Wellness Center? **Yes or No** If yes, do you want your child to have dental sealants on the same day as cleaning? **Yes or No**

If you selected to have your child receive cleanings and/or sealants, signing this enrollment form will provide consent for him/her to participate in the portable dental services and confirms that your child does not already have a dentist.

INSURANCE INFORMATION – Please complete all that apply. **Please provide a copy of front and back of card.

- ☐ **Primary Health Insurance:** Name of Insured Parent / Guardian_____
  Date of Birth of Card Holder_____ SSN of Card Holder _____
  Address (if different from child):_____
  Place of Employment _____
  Name of Insurance Company _____
  ID Number _____
  Group Number _____
- ☐ **Secondary Health Insurance**: Name of Insured Parent / Guardian_____
  Date of Birth of Card Holder_____ SSN of Card Holder _____
  Address (if different from child):_____
  Place of Employment _____
  Name of Insurance Company _____
  ID Number _____
  Group Number _____
- ☐ **Dental Insurance**: Name of Insured Parent/Guardian:_____
  Date of Birth of Card Holder_____ SSN of Card Holder _____
  Address (if different from child):_____
  Place of Employment _____
  Name of Insurance Company _____
  ID Number _____
  Group Number _____
- ☐ **No health insurance / Request application for sliding fee**

Parent/Guardian Initials: _____

- **I would like assistance from Coplin Health Systems to obtain insurance**

INCOME INFORMATION – Please complete all that apply. Please Circle the Following:

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9
What is your estimated household monthly net income?
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000
My child qualifies for free or reduced lunch: Yes or No

Sliding Scale Fee information

Even if you have health insurance, this program may help you with the cost of health care at our facility. This program is offered through Coplin Health Systems and may pay a portion of the costs for office visits. Families with insurance may qualify for deductible and co-pay discounts. Documentation required includes a Jackson County Schools Wellness Center enrollment and consent form, a completed sliding fee scale application with proof of total family income, and a copy of the two most recent check stubs for each person living in the household.

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian, with my signature of this form, give consent for my child to receive services at Coplin Health Systems' School-Based Wellness Center. I understand that this consent form will be good for one school year or until I provide Coplin Health Systems with written directions otherwise, whichever is shorter. All healthcare information is confidential. By signing the consent form you are giving Coplin Health Systems, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payers for billing purposes. Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. 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.

HIPAA OF 1996 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. This notice can be found on our website at www.coplinhealthsystems.com or by requesting a copy from Coplin Health Systems' staff. Your signature of this form certifies that you have reviewed the Notice of Privacy Practices. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Coplin Health Systems' care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

PARENT/GUARDIAN SIGNATURE

The information I have given is correct to the best of my knowledge. I understand that my medical information and/or that of my child will remain confidential and it is my responsibility to inform the Wellness Center staff of any changes in medical care and status.

_____ _____
Signature of Parent / Legal Guardian Date

Printed Name of Parent/Guardian _____

Parent/Guardian Initials: _____