Crossroad Health Center & The Dohn Community High School

Welcome & Enrollment Packet

School Based Health Center at Taft Elementary 2016-17

STUDENT/PATIENT Name: ______________________________________ **Date of Birth** ___/____/____ **Male/Female**

Child's Social Security # _______-__________-___________ Insurance ID: _______________________________________

Insurance: ☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ No Insurance ☐ OTHER___________________

Services Available through your School-Based Health Center

PRIMARY HEALTH CARE from Crossroad Health Center Provider at Taft Elementary SBHC:

☐ **YES,** I consent for my child to receive MEDICAL CARE.

*May include treatment for acute illness or injury that occurs at school, referral to medical specialists, and may include administering over-the-counter medications unless emergency services are needed. SBHC care also includes routine well-child care (e.g. work, daycare, and sports physicals), and appropriate immunizations. (Note: well-child care includes vision / hearing screening, urine / blood tests, and an external genital exam, when appropriate.) ***Please note: In Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.**

☐ NO, I do not wish for my child to receive MEDICAL CARE at the School-Based Health Center (SBHC)

⇨ ____ ____ ________________

Parent / Guardian Signature **Parent/Guardian Name** (PRINT) **DATE TODAY**

Phone (best) _______________________ Phone #2________________________ Phone #3________________________

____ __________ __________________

ADDRESS STREET APT CITY STATE ZIP

I agree to terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have the option to review both the CHD and Crossroad's **Notice of Privacy Practices,** available at the nurse's office. **Consent in effect until terminated in writing** by Parent/Guardian.

☛ WHY do we have a School Health Center & Nurse Practitioner?

We want to HELP:

1. Keep your child out of the *emergency room* – unless absolutely necessary.
2. Provide medical care – including diagnosis and prescriptions—if your child is sick at school.
3. Reduce the trouble and time involved in taking your child to a doctor or urgent care.

• **Do you NEED a REGULAR DOCTOR for your children?** We can help. Crossroad's Nurse Practitioner (NP) at Taft can become your child's regular medical provider. This means your children can also be seen at the Crossroads Health Center, 5 E. Liberty Ave. in Over-the-Rhine, -- even when school is not open.

• You are welcome to **KEEP your child's regular doctor.** The NP at school will communicate all care directly to your usual doctor.

• **Crossroad Taft School-Based Health Center (SBHC)** will **TRY TO CONTACT YOU immediately** if your child becomes sick or injured at school. Our medical staff will take appropriate action to keep your child safe and healthy during school hours. Please **NOTIFY SCHOOL** when you **CHANGE** phone numbers.

To provide health services for your child we need the following information:

Parent/Guardian Name: ______________________________ Relationship to child: ______________

Parent/Guardian's Date of Birth: ______/______/______ Your Social Security No: _____- _____- _____

Address:______________________________ City/State/ZIP______________________

Phone Numbers to reach you: (1)________________ (2) ________________ (3) ________________

- **Emergency Contact Person:**______________________ Phone(s):______________________

PLEASE inform School Nurse or Office when you CHANGE PHONE NUMBER! We must be able to reach YOU in an Emergency.

- Regular **Medical Doctor** or Clinic: ______________________ Child's last "well child" exam: ____________
- Regular **Dentist/**Clinic: ______________________ Date of last check-up: ____________
- Preferred **Pharmacy:** ______________________

Do you want a copy of the physical exam to go to your clinic or doctor? **☐ YES ☐ NO**

Your Child's Health History

1. **Is your child allergic to ANY medications?** ☐ No ☐ Yes Please list: ______________________
2. **Any <u>SEVERE</u> food or environment allergies?** Please list: ______________________
   *Does your child have an **Epi-Pen** for this allergic reaction?* ☐No ☐Yes
3. **Did your child have any of these problems?** ☐ Prematurity or birth weight under 5 lbs. ☐ Difficult delivery ☐ Poor/slow growth in infancy
4. **Does your child TAKE any medications NOW? or IN THE PAST?** ☐Yes Please provide name of medication and condition.
   ____
5. **Has your child had any operations, serious injuries, or hospitalizations?** ☐ Yes Please provide reason and dates.
   ____
6. **Has your child ever been pregnant?** ☐ No ☐ Yes If ***Yes***, how many living children has your child given birth to: _________
7. **Has your child been a victim of abuse?** ☐ No ☐ Yes

School Concerns: Explain any YES answers on the line provided.

Does your child have any LEARNING PROBLEMS?	☐ YES	☐ NO	______________________
Is your child in a special class (Special Ed / IEP / 504 Plan)?	☐ YES	☐ NO	______________________
Has your child repeated a grade?	☐ YES	☐ NO	______________________
Does your child get into trouble often at school?	☐ YES	☐ NO	______________________

What are your child's grades? ________________ ***Is this a change?*** ☐YES ☐ NO

Does your CHILD or any FAMILY MEMBER have or had any of these HEALTH problems? (Please Check)

	CHILD	FAMILY		CHILD	FAMILY		CHILD	FAMILY
Asthma or wheezing	_____	_____	ADHD / Behavior	_____	_____	Allergies / Hay Fever	_____	_____
Cancer (type)	_____	_____	Concussion	_____	_____	Depression / Mental Illness	_____	_____
Diabetes	_____	_____	Drug / Alcohol Use	_____	_____	Eczema / Skin Problems	_____	_____
Headache / Migraines	_____	_____	Hearing Problems	_____	_____	Heart Disease	_____	_____
High Blood Pressure	_____	_____	Nosebleeds	_____	_____	Seizures	_____	_____
Sickle Cell Disease / Trait	_____	_____	Stroke	_____	_____	Urinary Tract Infections	_____	_____
Poor Vision / Blindness	_____	_____	Wetting/soiling self day or night	____	_____			

<u>Other health concerns you may have about your child:</u>

- **Tuberculosis (TB) Risk Assessment:** Is your child in contact with any of the following persons: immigrants from another country, someone diagnosed or treated for TB, incarcerated children or adults, HIV-infected, homeless, nursing home residents, illegal drug users, or migrant farm workers? YES NO

- Please **circle YES or NO** below.

Diagnosed or treated for TB?	YES	NO	Is an immigrant?	YES	NO
Traveled to another country?	YES	NO	Has ever been in jail or 20/20?	YES	NO