School-Based Health Center Enrollment Packet

Please complete the attached enrollment packet and return to the health center or your child's teacher. Services offered include:

Physical/Well Child Exams **Treatment of Illness & Injury** **Prescriptions**
Sports Physicals **Lab Tests** **Chronic Illness Management**
Immunizations/Vaccines **Mental Health Counseling** **Dental Services**

This packet is available online if you would prefer to complete the enrollment packet electronically. The link to our online form is newriverhealthwv.com/sbh.
If you have questions, please call one of the locations below:

School Based Health Center Locations

Coal City Elementary – 304-683-6904
Fayetteville PK-8 – 304-900-5262
Independence High – 304-683-6905
Independence Middle - 681-539-3337
New River Intermediate - 304-465-2171
New River Primary – 304-465-21
Oak Hill High School – 304-469-6331
Oak Hill Middle School – 304-469-6331
Summersville SBHC – 304-883-3900
Valley PK-8 – 304-981-4983

Child's Name: _____

NEW RIVER HEALTH SCHOOL-BASED HEALTH CENTER ENROLLMENT PACKET

New River Health Association (NRHA) School-Based Health Centers (SBHC) or Wellness Centers provide students with medical, mental health, dental and health education services. SBHCs increase access to health care, and decrease missed school time for those students whose parents sign this consent. Please complete and sign the enrollment form and return it to the Wellness Center or school office.

- If you have a family doctor, you can still use the SBHC. Our services are especially convenient if your child gets sick or is injured at school. Counseling, dental services, health education and sports physicals are available, too, for students with consent.
- Parents are welcome to call the SBHC staff with questions and may accompany children to their appointment.
- This consent is valid if your child moves to another school with a NRHA SBHC, unless you direct us otherwise.
- NRHA will bill private insurance, Medicaid and CHIP for eligible students. No child will be denied services due to inability to pay. If you do not have insurance, the SBHC has information about plans for which you may qualify.
- A separate consent form will be sent home for parent/guardian signature before vaccines/immunizations are given.
- New River Health provides after-hours phone call coverage for all SBHC patients seven days a week. Call 304-469-2905 after hours with any health related concerns.

STUDENT/PATIENT INFORMATION

Name of Child: _____ _____/_____/_____ _____/_____/_____ _____
(Please list child's name as it appears on birth certificate) Date of Birth Child's Social Security Number Grade

Mailing Address: _____ Ethnicity: ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino

Male ☐ Female ☐ Race: ☐ White ☐ Black ☐ Asian Other:_____ Child's School: _____

PARENT/GUARDIAN INFORMATION

_____ _____ _____/_____/_____ _____/_____/_____
Parent/Guardian Name Relationship to Child Date of Birth Parent/Guardian Social Security Number

_____ _____ _____ _____
Home Phone Number Work Phone Number Cell Phone Number Parent/Guardian E-mail Address

Please list any individual other than yourself we can contact about medical care in case we can't reach you:

Name: _____Relationship to Child: _____ Home Phone: _____ Cell Phone: _____

Name: _____Relationship to Child: _____ Home Phone: _____ Cell Phone: _____

Name: _____Relationship to Child: _____ Home Phone: _____ Cell Phone: _____

Head of Household: _____ Total Number of People in Household: ____ Gross Monthly Household Income: $ _____

HEALTH INFORMATION

1) Is your child allergic to any medications? Yes ☐ No ☐ If yes, what? _____

Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes ☐ No ☐ If yes, what? _____

_____

2) List current prescription & non-prescription medications your child is taking:

Prescription or Non-Prescription medication	Reason for taking	Dosage
_____	_____	_____
_____	_____	_____

3) Has your child ever had any serious or sports related injuries or concussion? Yes ☐ No ☐ If yes, explain:_____

_____

4) Has there been any change in your child's health during the past year? Yes ☐ No ☐ If yes, describe the illness or injury: _____

_____

5) Has your child ever received mental health counseling services? Yes ☐ No ☐ If yes, when? _____

6) When was your child's last dental exam? _____Name of dentist: _____

7) Are there smokers in your house? Yes ☐ No ☐

8) If we need to call in a prescription for your child, which pharmacy would you like us to call? _____

9) Please mark any of the following conditions that the child has:

__Abuse/Neglect __Congenital Malformation __Drug Related Disorder __Hearing Loss __Speech Difficulties
__Congenital Heart Disease __Constipation __Eyesight Problems __Otitis Media (frequent) __Urinary Tract Infection (frequent)
__Enuresis (bedwetting) __Developmental Disorders __Fractures __Preterm Infant __Other: _____

10) Previous hospitalizations including dates: _____

_____

11) Please mark any prior surgeries:

__Adenoidectomy __Inguinal Hernia Repair __Orchiopexy __Other (please explain) _____
__Appendectomy __Myringotomy (tubes) __Tonsillectomy _____
__Gastrostomy __Nissen Fundoplication __Umbilical Hernia Repair

12) Living with (please circle): ***Parents*** ***Sisters*** ***Brothers*** ***Step-Family*** ***Grandparents*** ***Other Relatives*** ***Foster Care***

Family History	Child	Mom	Dad	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Brother	Sister
ADD/ADHD									
Allergies									
Anemia									
Asthma									
Autism Spectrum Disorder									
Birth Defect									
Blood Disorder									
Cancer									
Cerebral Palsy									
Congenital Abnormalities									
Coronary Artery Disease									
Diabetes									
Eczema									
Epilepsy/Seizures									
Gastrointestinal Disorders									
Heart Disease									
Hyperlipidemia									
Hypertension									
Immune/Autoimmune Disorder									
Intellectual Disability									
Kidney Disease									
Mental Illness									
Migraines/Headaches									
Substance Abuse									
Thyroid Disorder									
Tuberculosis									

13) In the past year, have there been any changes in your family such as: ☐ **Marriage** ☐ **Serious illness** ☐ **Change in school** ☐ **Moved** ☐ **Separation** ☐ **Loss of job** ☐ **Birth** ☐ **Divorce** ☐ **Foster Care** ☐ **Family incarceration** ☐ **Death** ☐ **Other: _____**

14) Does your child have a family doctor or pediatrician? Yes ☐ No ☐ Name of doctor: _____ date of your child's last complete physical exam (well-child exam)? _____ **Please attach a copy of your child's immunization record.**

15) Would you like for the SBHC to do a complete physical exam (well-child exam) on your child during the school year? Yes ☐

16) Does your child have any disabilities (physical disabilities, learning disabilities, special dietary needs, etc.)? Yes ☐ No ☐

If yes, please explain: _____

INSURANCE INFORMATION

Please complete all that apply and **provide insurance number or copy of card**

Insurance Carrier: _____ID Number: _____ Group Number: _____

Insured Parent/Legal Guardian for Private Insurance or CHIP: _____

Birth Date of Card Holder: _____ SSN of Card Holder: _____Card Holder Address: _____

Complete Address for Private Insurance Carrier: _____

Insurance Company Phone Number: _____ Place of Employment of Card Holder: _____

If child has Medicaid Insurance check the carrier: ☐ **Molina** ☐ **Unicare** ☐ **Aetna** ☐ **The Health Plan**

Medicaid ID# (11 digits):_____ Medicaid Carrier ID#: _____

If your child does not have health insurance please contact the SBHC for more information on insurance options for your child and family.

CONSENT TO SERVICES

The above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illnesses, prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child. I, the parent/guardian of said student, give consent for my child to receive services by New River Health School-Based Health Center staff. I understand that giving consent for my child to receive services may include nursing care, medical treatment (including dispensing of over the counter meds), and referral for counseling. I understand that this consent will be good until I provide the health center staff with written directions otherwise. If your child changes schools, this consent will be valid at all NRHA school health sites unless you advise us otherwise.

All healthcare information is confidential. By signing the consent below, you are giving the SBHC, 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. By signing below, you are giving permission for NRHA staff to photograph your child to be used for their Electronic Medical Record only. The health center may release information regarding treatment to third party payors for billing purposes.

Child's name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Relationship to Child: _____Date: _____

By signing below I am acknowledging that I have received a copy of the NRHA Notice of Privacy Practices (copy attached).

Signature for Privacy Practices: _____ Date: _____

DENTAL SERVICES ENROLLMENT

New River Health will offer preventive dental services at your child's school including: dental X-rays, cleanings, fluoride treatments, sealants, and exams by a licensed dentist. If your child needs further treatment, such as fillings, extractions or orthodontics, we will send home information on how to obtain these services at another location. If you would like your child to take advantage of the dental services offered in the school-based health centers, please read this form carefully, complete the questions sign and return.

Only complete the information below if you would like your child to receive dental services at their school-based health center.

☐ **Yes** - I would like for my child to receive dental services **(exams, sealants, fluoride, cleanings, x-rays)** at the School-Based Health Center and understand that my child may be referred to a local dentist for further treatment.

_____	_____	_____	_____
Child's Name	**Date of Birth**	**Parent/Guardian Signature**	**Date**

Does your child have a dentist: ☐ Yes ☐ No If yes, name of dentist: _____ Date of last visit? _____
List any food or drug allergies your child has: _____
List any medications your child is taking: _____
Does your child have any of the following conditions? ☐ Requires Pre-Med Antibiotics ☐ Blood Disorders ☐ Autism ☐ ADHD ☐ Seizures
☐ Heart Murmur ☐ Congenital Heart Disease ☐ Artificial Heart Valves ☐ Diabetes ☐ Other conditions not listed: _____
Please list any surgeries your child had in the past 5 years, and dates of each surgery. _____
_____

Child's Insurance Information – *Please complete all that apply and* provide insurance number or copy of card

Private Dental Insurance Information:

Name of Private Dental Insurance Carrier: _____ID Number: _____ Group Number: _____
Insured Parent/Legal Guardian for Private Dental Insurance or CHIP: _____
Birth Date of Card Holder: _____ SSN of Card Holder: _____ Phone Number: _____
Card Holder Address (if different from child): _____
Complete Address for Private Dental Insurance Carrier: _____
Insurance Company Phone Number: _____ Place of Employment of Card Holder: _____

☐ **My child has Medicaid Insurance** ☐ **My child has CHIP Insurance** ☐ **My Child does not have Dental Insurance**