



School Based Health Center Enrollment and/or Update Form MEDICAL – TALBOT COUNTY

Dear Parent/Guardian:

As a student in the Talbot County Public School system, your child has access to the Choptank Community Health SCHOOL BASED HEALTH CENTERS (SBHC).

SBHC are more than a visit to the school nurse's office. The SBHC are staffed with licensed medical providers including nurse practitioners and physician assistants just like a medical office. These licensed medical providers are able to assess patients, diagnose illnesses, perform lab testing, provide medications in school and write prescriptions. Your child can receive medical treatment right at school! There is no need to take time off from work to take your child to the doctor and/or travel to/from school, home and an off-site medical facility.

Services Available in the School Health Centers

- Congestion
- Earaches
- Follow-up Health Care Needs
- Health Risk Assessments
- Pain or Injuries
- Prescriptions
- Sore Throat Evaluation
- Nausea /Vomiting Evaluation
- Sports Physicals
- Cough
- Headaches
- Referrals to Specialists
- Health Education
- Skin Itch/Rash
- Shortness of Breath
- Strep Throat Tests

Asthma Action Plans

Your School Based Health Provider can assist with establishing an Asthma Action Plan, also called a treatment plan, which is a written plan that is developed in partnership with your doctor to help control your child's asthma. All students enrolled in "Wellness" with a diagnosis of asthma are eligible to receive education and monitoring. You and your child can learn to recognize the warning signs of an attack and how to stay away from things that trigger an attack. As we like to say:

Healthy Children are better learners!

ADDITIONAL INFORMATION

The mission of the Centers is to **improve the health of students and faculty, increase access to primary health care and decrease time lost from school by providing care** within the school setting. We are a **convenient source of quality health care** that works in collaboration with your child's doctor and the school nurse.

Choptank Community Health recognizes the connection between health and positive academic outcomes. CCHS is pleased to partner with the Talbot County Public Schools and Talbot Health Department to ensure that students are healthy and ready to learn.

Services: In addition to the services mentioned above, SBHC providers can assist in managing chronic illnesses, conduct *Healthy Child Chats*, provide health education, referrals to specialists and sports physicals for school endorsed sports. 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 is shared with your child's primary health care provider.

Cost: Federal and state regulations require all providers, including Choptank Community Health (CCHS), to bill all patients for School Based Health Center program services. The Medicaid programs cover School Based Health Center charges. 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 copays, unmet deductibles and any non-covered services. If CCHS is not a participating provider with your insurance plan, you will be billed directly for services. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their 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: All Talbot County Public School students can enroll in the program. Please complete the attached enrollment form. Return it to the school nurse or the Health Center. Once your child is enrolled in the Health Center, they will not need to re-enroll each year. If you have any questions about the program, please contact CCHS at (410) 479-4306, ext. 5012.

Choptank Community Health ❖ School Based Health Program Enrollment and/or Update Form

My child is a student at: _____ School ~ Grade _____

Student's name _____		
Last	First	Middle
Home address _____		
Street	City	State/Zip
Phone _____	Social Security# _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth _____	Race _____	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Language: _____		Homeroom _____
Email _____		

Parent/legal guardian name _____		
Relationship to student _____		
Address (if different than student) _____		
Phone: Home _____	Work _____	Cell _____
In case of emergency call:		
Name _____		Phone _____

DOES YOUR CHILD HAVE HEALTH INSURANCE?	
<input type="checkbox"/> YES, Please complete the following. <input type="checkbox"/> NO, Please send a Sliding Fee program application.	
Name of insurance company _____	
Policy/Medical Assistance # _____	
Group # _____	
Insurance billing address _____	
Policy holder name _____	Policy holder DOB _____
Does your child have a Doctor/Primary Healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Doctor/Primary Healthcare provider _____	
Address _____	Phone # _____
Pharmacy _____	
Name of Dentist _____	Phone # _____

I understand that my signature gives consent for the CCHS School Based Health Center Providers to treat my child and to communicate with my child's primary health care provider. I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. CCHS may also mail healthcare information to my home. I understand the student may request that visits remain confidential. Maryland Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, or contraception. Students age 16 and over may receive mental health services without parental consent. I understand that my child's health information will be used for treatment, payment and health care operations. I recognize that school directories may be used to obtain information left blank on the enrollment form. My child's immunization record may be shared between the School Nurse and the School Based Health Center. For the purposes of care coordination and case management TCPS Clinical Staff will have access to the SBHC health records. TCPS Clinical Staff are required to treat the information in the SBHC health record as confidential and comply with the HIPAA Privacy Rule. In no circumstance, do SBHC records become part of the student's school health record. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. If I do not have insurance, I will be billed for the full cost of services or with a sliding fee discount if applicable.

Parent/Guardian Signature _____ **Date** _____

School Based Health Program Student Health History

STUDENT'S NAME _____ Date of Birth _____

List all medications your child takes daily or on a regular basis:

Medication _____ mg _____ Directions _____

Medication _____ mg _____ Directions _____

Medication _____ mg _____ Directions _____

Does your child have Allergies to:

Medication No Yes Name of medication(s) _____

Reaction to medication(s) _____

Food No Yes Source of Allergy _____

Environmental No Yes Source of Allergy _____

Does your child have a doctor's order for an EpiPen? No Yes

Does anyone in your home smoke? No Yes

Hospitalizations:

Reason _____ Date _____

Reason _____ Date _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? CONDITIONS	CHECK ALL CONDITIONS THAT APPLY TO THE STUDENT	WHICH FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING CONDITIONS? FAMILY MEMBER	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
ADD/ADHD			
ANEMIA			
ASTHMA			
BLEEDING DISORDER			
CANCER			
DEPRESSION/MENTAL ILLNESS Would you like your child referred to a Mental Health Counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
DEVELOPMENTAL DISABILITIES			
DIABETES			
DRUGS/ALCOHOL/TOBACCO USE BY STUDENT/HOUSEHOLD			
FREQUENT COLDS			
FREQUENT EAR INFECTIONS			
HEARING/VISION PROBLEMS/LOSS			
HEART PROBLEMS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
KIDNEY/BLADDER PROBLEMS			
LEAD POISONING			
LIVER PROBLEMS (HEPATITIS)			
MIGRAINES			
STOMACH PROBLEMS			CONTINUE ON NEXT PAGE ►

NAME _____ Date of Birth _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? CONDITIONS	CHECK ALL CONDITIONS THAT APPLY TO THE STUDENT	WHICH FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING CONDITIONS? FAMILY MEMBER	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
OBESITY			
SEIZURE DISORDER (EPILEPSY)			
SKIN PROBLEMS (ACNE, ECZEMA, PSORIASIS)			
STROKE			
THYROID DISEASE			
TOOTH DECAY			
TUBERCULOSIS			
WHEEZING or TROUBLE BREATHING			
ANY OTHER HEALTH ISSUES:			

Birth History: Birth Order: 1 2 3 4 5 6 _____ Delivery Method Vaginal C-Section

Problems during pregnancy _____

During pregnancy, was your child exposed to: Medications: Y / N Drugs: Y / N Alcohol: Y / N Smoking: Y / N

Did your child go home from the hospital with you? If not, why? _____

	YES	NO
For children aged 0 – 6 years:		
1. Does your child live in or regularly visit a house* built before 1950?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child live in or regularly visit a house built before 1978 with recent renovations or remodeling done within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child have a sibling or playmate that has or did have lead poisoning? * Daycare, Babysitter or Relative's home	<input type="checkbox"/>	<input type="checkbox"/>
For children of all ages:		
1. Was your child born in, or lived more than 1 year in a country other than the US? Where? _____ When? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child been exposed to anyone who has ever had Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is your child currently living in a household with anyone who is HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your child part of a migrant worker family?	<input type="checkbox"/>	<input type="checkbox"/>

This information is for use by the School Based Health Centers and is not part of the Public-School records.

Signature of Parent/Guardian completing this form _____

Date _____

School Year _____