Talbot County Public Schools
School Based Health Centers

CHOPTANK community health
See how healthy you can be!

ENROLLMENT FORM & INFORMATION

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. Please complete the attached enrollment form and return to your school nurse. Once enrolled, they are enrolled through graduation!

We are a convenient source of quality health care that works in collaboration with your child's doctor, dentist and the school nurse. The School Based Health and Dental centers do not take the place of your Primary Care Provider or Primary Dentist.

SERVICES AVAILABLE IN THE SCHOOL BASED HEALTH CENTERS

- Diagnosis and Treatment of illnesses
- Behavioral Health Services
- Sports Physicals and Well Visits
- Nutrition/Dietician services
- Telehealth/Virtual Visits
- Health Risk Assessments
- Dental fluoride/sealants/cleaning
- Lab tests for acute illness
- Health Education
- Support for chronic diseases

School	Hours	Phone
Easton Elementary	Mon., Wed., & Fri., 7:30 am - 3:30 pm	443-496-3201 (T) | 883-914-0414 (F)
Easton Middle	Tues. & Thurs. 7:30 am - 3:30 pm	443-496-3202 (T) | 883-914-0415 (F)
Easton High	Mon. & Wed. 7:30 am - 3:30 pm	443-496-3203 (T) | 883-914-0416 (F)
St. Michaels Campus	Tues. & Thurs. 7:30 am - 3:30 pm	410-822-8724 (T) | 883-454-1985 (F)
White Marsh Elementary	Mon. & Wed., 7:30 pm - 3:30 pm	410-822-2219 (T) | 883-454-2071 (F)

We ensure that all students have access to School Based Health Center Services

FEE FOR SERVICE: 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.

SLIDING FEE PROGRAM: Patients on the sliding fee program can receive discounts that will be billed based upon their income. All patients and their families are eligible to apply for the sliding fee program, even if they have insurance. Please indicate on the enrollment form if you would like a slide fee application.

AFTER HOURS: MEDICAL AND DENTAL EMERGENCIES 443-329-9920

If you have any questions about the program, please contact CCHS at (410) 479-4306, ext. 1038

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School Based Health Center

MEDICAL & DENTAL ENROLLMENT/UPDATE FORM

Once enrolled, always enrolled!

SCAN HERE TO ENROLL ONLINE!

____ I want to enroll/update my child in the School Based Health Center and the School Based Dental Program.

____ I want to enroll/update my child in the School Based Health Center Only.

____ I want to enroll/update my child in the School Based Dental Program Only.

My child is a student at:____________________________ Grade: ______________ Homeroom Teacher:_________________

STUDENT INFORMATION

NAME: ____

ADDRESS: ____

____

DOB: ________________ Male / Female

SOCIAL SECURITY #:_________________________________

RACE: ____________________ HISPANIC/LATINO?: YES / NO

PREFERRED LANGUAGE: ____________________________

DOCTOR: _____________________PHONE: ____________

DENTIST: _____________________PHONE: ____________

PHARMACY: ___________________PHONE: ____________

PARENT/GUARDIAN INFORMATION

NAME: ____

RELATIONSHIP: ______________________________________

HOME PHONE: _______________________________________

MOBILE PHONE: ______________________________________

EMAIL: ____

OK TO TEXT?: YES/ NO

EMERGENCY CONTACT: ________________________________

RELATIONSHIP: ______________________________________

HOME PHONE: _______________________________________

MOBILE PHONE: ______________________________________

HEALTH INSURANCE

INSURANCE NAME: ___________________________________

POLICY/MEMBER ID#: _________________________________

GROUP #: ____

SUBSCRIBER NAME: ___________________________________

SUBSCRIBER DOB: ____________________________________

CLAIMS ADDRESS: ____________________________________

____

DENTAL INSURANCE

INSURANCE NAME: ___________________________________

POLICY/MEMBER ID#: _________________________________

GROUP #: ____

SUBSCRIBER NAME: ___________________________________

SUBSCRIBER DOB: ____________________________________

CLAIMS ADDRESS: ____________________________________

____

No insurance? Would you like to apply for the Sliding Fee? Yes / No

HEALTH/DENTAL HISTORY

DAILY MEDICATIONS: ____

ALLERGIES to MEDICATION / FOOD / ENRIVONMENTAL : ____

YES / NO HAS YOUR CHILD HAD ANY RECENT HOSPITALIZATIONS OR PREVIOUS SURGERIES?

IF YES, PLEASE LIST: ____

YES / NO DOES ANYONE IN THE HOME SMOKE? YES / NO DRUG/ALCOHOL ADDICTION?

YES / NO HAS YOUR CHILD COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO DOES YOUR CHILD HAVE HISTORY OF TOOTH DECAY?

YES / NO HAS YOUR CHILD SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: ____/____/______

For office use only. Entered: ____ Scanned: ____ P: ____ FI2: ____ OHI: ____ S: ____

Complete & Sign Page 2

STUDENT NAME: DOB:

STUDENT HISTORY

HAS CHILD EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES/NO	ADOPTED - Medical History Unknown
YES / NO	ADD/ADHD
YES / NO	ANEMIA
YES / NO	ASTHMA /BREATHING
YES / NO	AUTISM
YES / NO	BLOOD DISORDER
YES / NO	CANCER
YES / NO	DEVELOP. DISABILITY
YES / NO	DIABETES
YES / NO	HEADACHES/MIGRAINE
YES / NO	HEARING/VISION
YES / NO	HEART CONDITION*
*If YES, is pre-med required by cardiologist?: YES / NO	
YES / NO	HIGH BLOOD PRESSURE
YES / NO	HIV/AIDS
YES / NO	KIDNEY/BLADDER
YES / NO	LEAD POISONING
YES / NO	LIVER PROBLEMS
YES / NO	MENTAL HEALTH DISORDER
YES / NO	OBESITY
YES / NO	SEIZURES/EPILEPSY
YES / NO	SKIN PROBLEMS
YES / NO	STOMACH PROBLEMS
YES / NO	STROKE
YES / NO	THYROID PROBLEMS
YES / NO	TUBERCULOSIS

OTHER INFO: ____________________

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER (parent, sibling, grandparent) EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES / NO	ADD/ADHD	Who?: ____________
YES / NO	ANEMIA	Who?: ____________
YES / NO	ASTHMA /BREATHING	Who?: ____________
YES / NO	AUTISM	Who?: ____________
YES / NO	BLOOD DISORDER	Who?: ____________
YES / NO	CANCER	Who?: ____________
YES / NO	DEVELOP. DISABILITY	Who?: ____________
YES / NO	DIABETES	Who?: ____________
YES / NO	HEADACHES/ MIGRAINE	Who?: ____________
YES / NO	HEARING/VISION	Who?: ____________
YES / NO	HEART CONDITION	Who?: ____________
YES / NO	HIGH BLOOD PRESSURE	Who?: ____________
YES / NO	HIV/AIDS	Who?: ____________
YES / NO	KIDNEY/BLADDER	Who?: ____________
YES / NO	LEAD POISONING	Who?: ____________
YES / NO	LIVER PROBLEMS	Who?: ____________
YES / NO	MENTAL HEALTH DISORDER	Who?: ____________
YES / NO	OBESITY	Who?: ____________
YES / NO	SEIZURES/EPILEPSY	Who?: ____________
YES / NO	SKIN PROBLEMS	Who?: ____________
YES / NO	STOMACH PROBLEMS	Who?: ____________
YES / NO	STROKE	Who?: ____________
YES / NO	THYROID PROBLEMS	Who?: ____________
YES / NO	TUBERCULOSIS	Who?: ____________

OTHER INFO: ____

I understand that my signature gives consent for the CCHS School Based Health/Dental Center Providers to treat my child and to communicate with my child's primary health care provider. I give CCHS permission to call my home, leave a message regarding healthcare information. CCHS may also mail healthcare information to my home.

- I understand that my child's health information will be used for treatment, payment and health care operations.
- I recognize that school directories will 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/Dental Centers. For the purposes of care coordination and case management, School Clinical Staff will have access to the SBHC/SBDP health records and School Clinical Staff shall share health information with the SBHC/SBDP staff. School Clinical Staff are required to treat the information in the SBHC/SBDP health record as confidential and comply with the HIPAA Privacy Rule and the FERPA Act.
- 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 12 and over may receive mental health services without parental consent. Under no circumstances, do SBHC/SBDP 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.
- 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. We participate in the CRISP health information exchange ("HIE") to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.
- If I do not have insurance, visit costs will be billed for the full cost of services or at a reduced rate with a sliding fee discount, if applicable. I will be offered a Sliding Fee Application whether or not I have health/dental insurance.

Our privacy forms can be found online at choptankhealth.org/formsinformation.

Parent/Guardian Signature: ________________________________ Date: ____________

PLEASE RETURN COMPLETED ENROLLMENT TO YOUR SCHOOL NURSE. THANK YOU!