CHOPTANK community health

see how healthy you can be!

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

Dear Parent/Guardian:

As a student in the Caroline 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 Caroline County Public Schools and Caroline 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 Caroline 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# _____ ☐ Male ☐Female

Date of Birth _____ Race _____ Hispanic/Latino? ☐ Yes ☐ 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?

☐ YES, please complete the following. ☐ 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? ☐ Yes ☐ 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 CCPS Clinical Staff will have access to the SBHC health records. CCPS 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? Yes / 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 ►

STUDENT'S 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? _____

For children aged 0 – 6 years:	**YES**	**NO**
1. Does your child live in or regularly visit a house* built before 1950?	☐	☐
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?	☐	☐
3. Does your child have a sibling or playmate that has or did have lead poisoning?	☐	☐
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? _____	☐	☐
2. Has your child been exposed to anyone who has ever had Tuberculosis?	☐	☐
3. Is your child currently living in a household with anyone who is HIV positive?	☐	☐
4. Is your child part of a migrant worker family?	☐	☐

* Daycare, Babysitter or Relative's home

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 _____