School Based Health Center Registration Form

PATIENT INFORMATION: (Please be sure to complete all sections)

School name:________________________Grade____________

Child's legal name: ___________________________________

Sex at birth: M / F Gender Identity: ______________________

Sexual Orientation: ___________________________________

Address:____

City, State, Zip____

County or city:____

Child's date of birth (month/day/year):____________________

Email:____

Parent or guardian name:________________________________

Best phone number to reach parent:______________________

Alternate phone number:________________________________

Because we receive federal assistance, we are required to collect the following information.

What is your child's race? Check all that apply.

___American Indian or Alaska Native
___Asian
___Native Hawaiian or other Pacific Islander
___Black or African American
___White
___Other Race______________________
___Unreported/Refused to report

Ethnicity: Hispanic / Non-Hispanic / Other ________________

Language: English/ Spanish/ Other______________________

Veteran: Yes / No

Migrant: Yes / No

Homeless: Yes / No

How many people are living in your household, including yourself?_____

What is the estimated total annual income for your household,

Including government assistance and disability?

___under $11,000
___$11,001 - $15,000
___$15,001 - $20,000
___$20,001 - $25,000
___$25,001 - $30,000
___$30,001 - $35,000
___$35,001 - $45,000
___$45,001 - $55,000
___over $55,000

MEDICAL INFORMATION: (Please be sure to complete all sections)

Primary Care Physician's name: ___________________________

Primary Care Physician's phone: ___________________________

Pharmacy: ____

Other health care providers_________________________________

Does your child take medications on a routine basis?______yes____no

If Yes, please list:____

____

Does your child have allergies: _____yes _____no

If yes, check all that apply:____________________________

___Seasonal_______________________________
___Antibiotics_____________________________
___Latex_________________________________
___Medications____________________________
___Food__________________________________
___Other_________________________________

Does your child need antibiotics before dental treatment?___yes___no

If yes please explain:____

INSURANCE INFORMATION

Medical Insurance (if have)

Primary Insurance Company:________________________________

Insurance plan and/or group number:_________________________

Subscriber name: ____

Subscriber date of birth (month/day/year): ______________

Subscriber SSN: _______________________

Dental Insurance (if have)

Does your child have Medicaid? ____Yes ____No

If yes, include your child's RECIPIENT ID NUMBER________________
(12-digit ID number on the front of the Medicaid card)

Is your child covered by PRIVATE dental insurance?__Yes___No

If yes, please fill out ALL the insurance information below:

Dental Insurance Company:_____________________________________

Insurance Company address:___________________________________

Dental Insurance plan and/or group number:______________________

Subscriber name:____

Subscriber date of birth (month/day/year):_______________________

Subscriber SSN: ____

PLEASE COMPLETE OTHER SIDE **RETURN BY 8-26-2024**

SCHOOL BASED HEALTH CENTER (SBHC) PROGRAM CONSENT FORM

Dear Parent or Guardian,

The Rockbridge Area Health Center (RAHC) is expanding our service offering to the Rockbridge County Public School System (RCPS) for the 2024-2025 school year. In addition to dental services, we will also be providing medical and behavioral health services. The dental services will be provided as they have been for the previous 12 years at your child's school by licensed dentists and dental hygienists. Medical services will be provided by licensed independent practitioners and behavioral health services by a master's level Supervisee in Social Work under the supervision of Mariah McMillan, LCSW; Counselor in Residence under the supervision of Abigail Sorrells, LPC. Medical and behavioral health will be available at Maury River Middle School and Rockbridge County High School, but all RCPS students are eligible to receive services. A brief description of the services provided for each service is on the following page. For your child **to receive these services,** you must provide **ALL THE INFORMATION** requested, select the services you would like your child to receive and **SIGN** in the area indicated.

I understand that if my child requires SBHC services, reasonable attempts will be made to contact me and if I cannot be reached:

	I DO give	**I DO NOT give**
Dental	☐	☐
Medical	☐	☐
Behavioral Health	☐	☐

consent for my child to be seen by the providers at the SBHC. I understand if I cannot physically attend the appointment, I have the option to attend via audio (phone) or secure audio/video (telehealth).

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED IF SERVICES ARE WANTED.

I am a custodial parent or legal guardian of the minor child named below. **I authorize and consent to** this child receiving the services indicated above and allow the school nurse/ school representative and RAHC providers access to the child's health record and school record. Following the Health Insurance Portability and Accountability Act (HIPAA) rules, **I authorize and consent** to SBHC staff members using and sharing my child's personal health information (PHI) for 1) treatment of my child's health condition and maintaining the continuity of my child's care. 2) payment for health services provided to my child and 3) routine health care operations including quality improvement, accreditation, and educational purposes or other disclosures required by law.

Student's Name: ____ DOB: ____________________

School Name: ____

CHECK ONE: Parent____ Legal Guardian_____

If you are legal guardian, you must include a copy of guardianship documentation.

Printed Name of parent/legal guardian: ____

Relationship to student: ____________________

Signature of parent/legal guardian: ________________________________DATE:_______________

Services provided at school-based health center (SBHC):

<u>Dental (Provided at your child's school)</u>:

- Exam
- X-rays
- Prophylaxis (teeth cleaning)
- Fluoride treatment
- Sealants (a protective coating on the chewing surfaces of back teeth)

If you currently take your child to see a dentist every 6 months for routine care, we encourage you to continue to seek care at that office and you do not need to select dental services on this form. TELL-SHOW-DO technique is often used to gain the confidence and cooperation of the dental patient. The dental provider explains what they are going to do, then shows what they are going to do with instruments on a model. Most patients do not encounter any difficulties with their treatment. If the patient indicates any strong resistance to the dental procedure, we will discontinue the treatment. You will be notified of the results of your child's visit.

<u>Medical (Provided at Maury River Middle School and Rockbridge County High School)</u>:

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Routine lab tests
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Vision and hearing screening and treatment
- Sexual wellness services
- Infection disease screening (flu, strep COVID-19)
- Immunizations provided on a scheduled basis
- Nutrition counseling provided on a scheduled basis
- Referrals for services not provided at the SBHC

Copies of visit summaries will be provided to the patient portal and your PCP upon request.

<u>Behavioral/Mental Health (Provided at Maury River Middle School and Rockbridge County High School)</u>:

- Behavioral/mental health assessment, screening, and intervention (additional parental/guardian consent required for children under the age of 18)
- Drug or alcohol use treatment

Copies of visit summaries will be provided to the patient portal and other care team providers upon request, PCP, psychiatrist etc.

RAHC will encourage every student to involve their parents/legal guardians in health care decisions, however, under Virgina law, children 14 and older can request mental health, substance use, and sexual health treatment without the consent of an adult.

Important information explaining Virgina law regarding adolescent proxy authorization to medical records is explained on the next page. By law RAHC is required to restrict full access to medical records, including the patient portal, to parents when the patient turns 13, and restrict full access when the patient turns 18. Patients may authorize full medical record access to parents, by signing an authorization.

Proxy Access:

	Partial Access With partial access, parent(s)/ guardian(s) can: • Update demographic information • View office hours, locations, and providers • View your child's immunization history • View your account balance	**Full Access** With full access, parent(s)/ guardian(s) can: • Access all partial access permissions • Schedule appointments • Communicate with your practitioer • View and request labs • View your child's complete medical file
 0 - 12 years old	 **Partial access does not apply.**	 **Full access is automatically given to parent/guardian.**
 13 - 17 years old	 **Previous full access is lost the day the patient turns 13 and partial access is given.**	 **Full access is given to parent/guardian if authorized by patient.**
 18 years +	 **Previous proxy access expires the day the patient turns 18.**	 **Full access may apply to adults including parent/guardian if authorized by patient.**