Minnie Hamilton Health System

SCHOOL BASED HEALTH CENTER (SBHC)
ENROLLMENT AND CONSENT FORM

(304) 354-9732 (Calhoun SBHC)
(304) 354-9244 (After School)

(304) 462-3415 (Gilmer SBHC)
(304) 462-7322 (After School)

STUDENT INFORMATION *

Student Name:_____ Student SS #:_____
Address:_____ Email Address:_____
City/State/Zip: _____
Cell:_____ Grade:_____ Birth date: _____
Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:* _____
School: ( ) CMHS ( ) Arnoldsburg Elementary ( ) Pleasant Hill Elementary
( ) GCHS/Middle School ( ) Gilmer County Elementary
( ) Little Kanawha Valley Christian ( ) Normantown Christian School

PARENT / GUARDIAN INFORMATION

Father:_____ Phone (H)_____ (W)_____ (C) _____E-mail _____
Mother:_____ Phone (H)_____ (W)_____ (C) _____E-mail _____
Guardian:_____ Phone (H)_____ (W)_____ (C) _____E-mail _____
Emergency Contact:_____ Phone (H)_____ (W)_____ (C) _____E-mail _____

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive Medical treatment including immunizations and procedures as deemed necessary, Dental and Behavioral Health services at the School Based Health Care facility. I understand this consent will remain in effect until my child leaves/graduates school or until I provide the School Based Health Center staff with written documentation revoking the consent.

All healthcare information is confidential. By signing the consent form you are giving the SBHC, school nurse and your child's regular primary care provider permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes. All co-pays and deductibles shall remain the responsibility of the patient guarantor.

Confidentiality between the student, parents and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

With my consent, Minnie Hamilton Health System and its providers have the ability to view my child's external prescription history via SureScripts for the purpose of his/her care and treatment. I understand that my child's medication history obtained from other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my child's providers to better coordinate his/her care and to maximize the effectiveness and safety of his/her treatment plan.

I understand that when I provide my email address or designate an alternate email address for a delegate of my choosing, this will allow access to my child's electronic protected health information through the secure patient portal.

_____ _____

Signature of Parent / Legal Guardian **Date**

PLEASE SEE OTHER SIDE

MINNIE HAMILTON HEALTH SYSTEM
186 HOSPITAL DRIVE, GRANTSVILLE, WV 26147

Minnie Hamilton Health System

HEALTH HISTORY INFORMATION

1. Please provide any Medical and/or Surgical History: _____
   Allergies: ☐None ☐Yes: (List) _____
   Medications: ☐None ☐Yes: (List) _____
2. Primary Care Physician: _____ Phone: _____
3. If your child has not had a physical exam within the last year please initial here if you would like your child to have a comprehensive physical exam (**well child check**) completed at the SBHC: _____
4. Preferred Pharmacy: _____ Location: _____
5. How often does your child go to the dentist? At least once a year___ Only with toothaches___ Never____
6. Does your child have a regular dentist? ( ) Yes ( ) No Name:_____
   (a) Date of Last Dental exam:_____ Dental x-rays? If yes, when and where:_____
   (b) Orthodontic treatment (braces)? If yes, please list dentist:_____
   (c) **I would like my child to have (please check only one)**: (Calhoun SBH only)
   - Preventative Dental Services ONLY (Exam, X-ray, cleaning, Fluoride Treatment, Sealants)
   - **All Dental Services** including preventive and restorative services (Fillings, Extractions, Local anesthetic)
   - No School Based Dental Service
7. My child has a current behavioral health diagnosis (ADHD, Depression, Anxiety) ( ) Yes ( ) No
   - My child already sees a clinician for behavioral health outside the school setting
   - I would like for my child to be evaluated for services in the next 30 days

Signature:_____ **Date:**_____

Payment Method – ***Please check all that apply and send a copy of the front and back of your insurance card(s):***
( ) INSURANCE ( ) MEDICAID/CHIP ( ) SLIDING FEE ( ) NONE / PRIVATE PAY

☐ **No health insurance / Request application for sliding fee / CHIP / Medicaid**

☐ **Primary Health Insurance:**
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Address (if different from child) _____
Name of Insurance Company:_____ Address:_____
Insurance Phone/Fax Number:_____ Group & ID Number _____

☐ **Secondary Health Insurance (if applicable)**:
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Name of Insurance Company _____ Address:_____
Insurance Phone/Fax Number:_____ Group & ID Number _____

☐ **Medicaid: (Please circle one) Health Plan Unicare WvDow WV Family Health Aetna**
Medicaid ID#:_____ Member ID# _____
PCP/HMO Provider:_____ Provider Phone Number: _____

☐ **CHIP:** Name on Card:_____ Birth date of card holder:_____
ID or PIN # on card:_____ Group #: _____

☐ **Dental Insurance** : Name of Insurance:_____ ID #:_____
Subscriber's Name:_____ Subscriber's DOB:_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Please note that there is an attached copy of HIPAA to this consent form, for the parent/guardian of the student receiving medical or mental health counseling services at [SBHC Name]. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services.

I certify that a copy of the Health Insurance Portability and Accountability Act of 1996 was provided with the Calhoun/Gilmer County School Based Health Center (SBHC) consent form, to the parent/guardian of _____ on this date.

Student Name

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of SBHC Health Staff Date