Southern Local Wellness Center (operated by Coplin Health Systems)

920 Elm Street, Racine, OH 45771 Phone: 740 949-2348 Fax: 740 949-2536

STUDENT INFORMATION

Student Name: _____ Student SS #: _____

Address- City: _____ Birth date: _____

State/Zip: _____ _____ Email: _____

Phone/Cell:_____ Grade: _____ Homeroom teacher: _____

Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:* _____

PARENT / GUARDIAN INFORMATION

Father: _____ Phone (H)_____

(W)_____ (C) _____ Email: _____

Mother: _____ Phone (H)_____

(W)_____ (C) _____ Email: _____

Guardian: _____ Phone (H)_____

(W)_____ (C) _____ Email: _____

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact, If I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Name: _____ Relationship: _____ May we leave a message? __ Y __N

Phone: _____ _____ _____

Home Work Cell

Health Information (Additional health, family & developmental history may be collected if seen at the clinic)

Doctor's name _____ **Last date of well child exam**_____ **If your child has not seen a Doctor within the last year would you like your child to have a well child exam at our wellness center? ____yes ____no**

Name of Dentist: _____ **Last date seen by dentist** _____ **If your child has not seen a Dentist within the last year would you like your child to have a cleaning and apply sealants at our wellness center? ____yes ____no**

If we need to call in a prescription, which pharmacy would you like us to call? _____

__Yes __No I give the Wellness Center permission to give my child Tylenol, Motrin, Tums, and cough drops as needed

*** **Signature:** _____**Date:**_____

INSURANCE INFORMATION – Please complete all that apply. *** **Please provide copy of front and back of card.**

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

Child's Insurance Information – ***Please check all that apply and send a copy of your insurance card(s)***

☐ **Primary Health Insurance:** Name of Insured Parent / Guardian_____

Birth date of Card Holder_____ SSN of Card Holder _____

Address (if different from child):_____

Place of Employment _____

Name of Insurance Company _____

Group & ID Number _____

☐ **Secondary Health Insurance:**

Name of Insured Parent / Guardian_____

Birth date of Card Holder_____ SSN of Card Holder _____

Name of Insurance Company _____

Group & ID Number _____

☐ **Medicaid: Caresource Molina Other _____(please circle one)**

Medicaid ID#: _____ Member ID# _____

PCP/HMO Provider: _____ Provider Phone Number: _____

INCOME INFORMATION – Please complete all that apply. **Please Circle the Following:**

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income? $100–500 $501-$1000 $1000 –$1500 $1501-$2000 $2001-$2500 $2501-$3000 $3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

My Child qualifies for free or reduced lunch _____ Yes _____ No **Sliding Scale Fee information:** Even if you have health insurance, this program may help you with the cost of health care at our facility. This program is offered through Wirt County Health Services Association and may pay a portion of the costs for office visits at the Southern Local Schools Wellness Center. Families with insurance may qualify for deductible and co-pay discounts. Documentation required include a Southern Local Schools Wellness Center enrollment and consent form indicating how many people live in the household with the total family income and a copy of the two most recent check stubs for everyone in the household.

CONSENT FOR SBHC (School Based Health Center) SERVICES, the parent/guardian of said student, give consent for my child to receive services at Southern Local Schools Wellness Center SBHC. I understand that this consent form will be good until my child leaves/ graduates school or until I provide the Center staff with written directions otherwise. All healthcare information is confidential. By signing the consent form you are giving the SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that 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 payers for billing purposes. Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that 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.

_____ _____ _____ _____

***Student Name Date of Birth *** Signature of Parent / Legal Guardian Date

_____ _____

***Signature of Witness (this can be anyone) Date

HIPPA OF 1996 ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPPA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. Please note there is an attached copy of HIPPA to this consent form, for the parent/guardian of the student receiving medical, dental or mental health counseling services at Southern Local Schools Wellness Center. You must sign below, indicating that you have received a copy of our HIPPA policies, prior to the student receiving services. I certify that I have received a copy of Southern Local Schools Wellness Center's Notice of Privacy Practices (HIPPA). The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Southern Local Schools Wellness Center's health care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. *The Notice of Privacy Practices is also posted in the waiting areas.*

*****Signature of Patient or Personal Representative**_____ **Date**_____

*****Printed Name of Patient or Personal Representative** _____

Description of Personal Representative Authority _____

*Witness Signature*_____ Date _____

MEDICATIONS TAKEN DAILY OR AS NEEDED BASIS: _____

_____

ALLERGIES to Medication:_____Food:_____Other:_____

Does the child have an order for and carry any of the following: ____ Epi Pen ____ Insulin ___ Glucagon____ Inhaler

The information I have given is correct to the best of my knowledge. I understand that my medical information will remain confidential and it is my responsibility to inform the Wellness Center Staff of any changes in medical care and status.

*****Parent/Guardian Signature** _____ **Date**_____