Chesapeake
HEALTH CARE

CHESAPEAKE HEALTH CARE

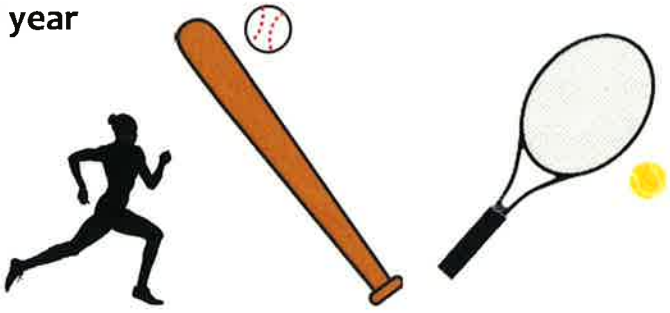
Washington High School
School Based Health Center

SPORTS PHYSICAL CLINIC

NOVEMBER 10TH, 2016

8AM – 12:45PM

- Health care for WHS students to improve their health, school attendance and school performance during the school year
- Pediatrician and skilled nurse on site
- EKG and bloodwork capability



- Guardian of child must complete and sign the medical history form and consent before appointment and fill out the sports physical questionnaire

Please call 410-651-4040

Or

410-651-1000

To make an appointment and verify insurance eligibility and/or payment

THREE LOWER COUNTIES Community Services, Inc.

P.O. Box 1978
Salisbury, MD 21802
410-749-1015 – Fax 410-749-1020

Dear Parent/Guardian:

As a student in the Somerset County School system, your child has access to the Three Lower Counties Community Services School Based Health Center at Washington HS. The mission of school based health is to improve the health of students, 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 staffed by nurse practitioners, dental hygienists and licensed behavioral health counselors who work in collaboration with your child's doctor and the school nurse. Your child can receive medical, dental and behavioral health treatment right at school!

Services: Treatment for minor health issues/injuries, assistance in managing chronic illnesses, prescriptions, health assessments, routine lab/diagnostic tests, health education, referrals to specialists and sports physicals. Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report of the visit is shared with your child's primary doctor and a copy maintained at the School Based Health Center.

Cost: Federal and state regulations require all providers, including Three Lower Counties Community Services, 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 TLC, Inc. for copays and/or deductibles. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon 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 Washington High School students can enroll in the program. Please complete the attached Enrollment, Release of Information and Health History forms. Return them 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 SCPS Nurse Manager, 410-621-6247. If you would like to schedule an appointment, please call Three Lower Counties Community Services, 410-651-1000, press Option "2" and speak with staff.

" PLEASE PRINT "

TLC SBHC @ WHS

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

Grade _____ Homeroom _____

Parent/Legal Guardian Name _____

Relationship to Student _____

Address (if different than student) _____

Phone: Home _____ Work _____ Cell _____

In case of emergency call:

Name _____ Phone _____

Name _____ Phone _____

Does your child have health insurance?

☐ No, please send a sliding fee program application.

☐ Yes, please complete the following:

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 # _____

Name of Dentist _____ Phone # _____

Pharmacy _____

I understand my signature gives consent for the TLC SBHC @ Washington HS to treat my child and to communicate with my child's primary health care provider. I understand my signature indicates I have received a copy of the Notice of Privacy Practices. I understand my signature indicates consent to a query of medication claims to my insurance company, allowing electronic entry of prescribed medications in my child's chart. I give TLC SBHC @ Washington HS permission to call my home, leave a message on a machine or with a person, regarding healthcare information. TLC SBHC @ Washington HS may also mail healthcare information to my home. I understand the student may request 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 my child's health information will be used for treatment, payment and health care operations. I recognize school records may be used to obtain information left blank on the enrollment form. I understand services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from TLCCS for copays and/or deductibles. If I do not have insurance, I will be billed based upon my income. TLCCS will have access to the SBHC patient health records for the purpose of attaining health care information.

Parent/Guardian Signature _____ Date _____

TLC SBHC @ WHS – Student Health History School Year _____

NAME _____ DOB_____ GRADE _____

List all medications your child takes daily or on a regular basis:

Medication _____ mg _____ Directions _____

Medication _____ mg _____ Directions _____

Medication _____ mg _____ Directions _____

Allergies:

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 THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **FAMILY MEMBER**	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
ADD/ADHD			
Anemia			
Asthma			
Bleeding Disorder			
Cancer			
Mental Health Would you like your child referred to a Mental Health Therapist? Yes / No			
Diabetes			
Drugs / Alcohol / Tobacco Use By Student/Household			
Frequent Colds			
Frequent Ear Infections			
Stomach Problems			
Hearing/Vision Problems/Loss			
Heart Problems			
High Blood Pressure			
High Cholesterol			
Kidney/Bladder Problems			
Lead Poisoning			
Liver Problems (Hepatitis)			
Learning Disability			
Migraines			

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? **CONDITIONS**	CHECK ALL THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **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? _____

This information is for use by the School Based Health Center and is not part of the Washington High School records.

Student's Name _____ DOB _____

Signature of Parent/Guardian completing this form _____

Date _____

School Year _____