MINOR PATIENT REGISTRATION: SCHOOL YEAR 2021-2022

By completing this form, I consent in advance to my child having access to any and/or all available school health services provided by Rockcastle Pediatrics and Adolescents *(RockPeds)* via telemedicine. Services include: diagnosis and treatment of common illnesses, infections and injuries, simple diagnostic laboratory testing, health education, and referrals as needed.

☐ By checking this box, I am saying I am **NOT** interested in my child receiving school clinic services provided by RockPeds at this time and I choose to **opt-out** of these services.

Students must have parental permission to receive school health services provided by RockPeds:

Student's Name (First, Middle, Last): _____

Date of Birth: _____ Soc Sec #: _____ Age: _____ Gender: M / F School: _____

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _____ Parent Email: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Who does the child live with most of the time?: _____

In Case of Emergency, who is a local friend or relative (not living at the same address) whom we could contact:

Name: _____ Relationship: _____ Phone: _____

Name of person responsible for the bill: _____

Is this patient covered by insurance?: YES / NO

If so, Please fill in all of the following: **Please provide a front/back copy of the student's medical insurance card.**

Primary Insurance Company: _____ Co-Pay amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ D.O.B: _____ S.S.N: _____

Patient's relationship to subscriber: SELF / SPOUSE / CHILD / OTHER: _____

Secondary Insurance Company: _____ Co-Pay amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ D.O.B: _____ S.S.N: _____

Patient's relationship to subscriber: SELF / SPOUSE / CHILD / OTHER: _____

Student is an established patient of RockPeds: YES / NO

Primary Care Doctor/Clinic: _____

Pharmacy: _____ Location: _____

No services can be provided without the FULL completion of this page and the following pages with parent/guardian signature.

(OVER)

MINOR PATIENT REGISTRATION: PAGE 2

Child's Name: _____ D.O.B: _____

HIPPA/FERPA: All students have health issues that must be handled in a confidential manner. RockPeds staff will share confidential information only in the following situations:

1. When it is educationally relevant for a student's academic progress.
2. When it is necessary to address a student's potential health care needs.
3. To ensure safety of the student, other students, and school personnel.
4. Other situations specified by law.

For example, RockPeds staff may discuss the student's medication and other health care needs with the appropriate staff members who will administer the student's medicine and provide care to the student while the student is at school.

Additional detailed information about our Privacy Policies that govern Rockcastle Pediatrics and Adolescents are provided with this consent, please review.

TELEMEDICINE: Student encounters with RockPeds pediatrician or nurse practitioner will be performed using video-conferencing technology. Student will be at school in the presence of the school nurse and will be able to see and hear the RockPeds provider. Likewise, the RockPeds provider will be able to hear, see, and examine the student as if they were in the same room. The information transmitted will be used for diagnosis, treatment, and/or education. Safety measures are implemented to ensure the video-conference is secure, and no part of the encounter will be video or audio recorded.

I, the undersigned,

1. Understand that the services provided include: diagnosis and treatment of common illnesses, infections and injuries, simple diagnostic laboratory testing, health education, and referrals as needed.
2. Give permission and consent for my child to have treatment through and by Rockcastle Pediatrics and Adolescents. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
3. Give permission for RockPeds staff to receive information from the school about my child's health history.
4. Acknowledge that I have been offered a copy of the Notice of Privacy Practices.
5. Agree to release all records related to this treatment to my child's Primary Care Provider (if not a RockPeds provider.)
6. Agree that I will be responsible for all the costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility, including co-pays.
7. As a parent/guardian of the student named above, I:
    a. Authorize the release of any information necessary to process insurance claims for payment benefits to RockPeds.
    b. Authorize payment of benefits to RockPeds for services rendered.
    c. Have provided details of all insurance policies that cover my child.

The information above and on the preceding page is true and complete to the best of my knowledge.

Parent/Guardian Name (PRINTED): _____

Parent/Guardian Name (SIGNED): _____

Date: _____

(OVER)

MINOR PATIENT REGISTRATION: PAGE 3

Schools Student Health Questionnaire: School Year 2021-2022

Students must have parental permission to receive school health services provided by RockPeds:

_____

Last Name First Name Middle

Student's DOB Gender School

Does your child have any of the following conditions or health concerns?

- ☐ Allergies, other than medications (ex: peanuts, beestings): *(please list)* _____
- ☐ Asthma: *date of last asthma attack*: _____
- ☐ Seizures: *date of last seizure*: _____
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Sickle cell anemia
- ☐ Heart problems: *(please list)*: _____
- ☐ Bleeding disorders
- ☐ Orthopedic problems (bone or joint)
- ☐ Anxiety/depression
- ☐ Operations and/or hospitalizations: *(please list)*: _____
- ☐ Diseases in siblings: *(please list)*: _____
- ☐ Other: *(please list)*: _____

*If you checked ANY of the boxes of the above conditions, please explain:

_____

_____

_____

_____

Is your child on any medications?

- ☐ NO
- ☐ YES: *(please list)*: _____

Is your child allergic to any medications?

- ☐ NO
- ☐ YES: *(please list)*: _____

In signing this form, I am stating the following:

1. The information provided is up-to-date and accurate.
2. I will update RockPeds staff with any changes as soon as possible.

_____

Parent Signature Date

*If you would like to speak with our medical staff about your child's health, please contact **RockPeds** at:*

(606) 256-4148