



STUDENT ENROLLMENT & INFORMATION PACKET

School Year: 2022-2023

Patient Information

Name: _____ Grade: _____ School: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Social Security Number: _____ Primary Language: _____

Mother's/Guardian's Information

Name: _____

Date of Birth: _____ Race: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Employer: _____ Work Number/Ext: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email Address: _____

Father's/Guardian's Information

Name: _____

Date of Birth: _____ Race: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Employer: _____ Work Number/Ext: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email Address: _____

Person to Notify in Case of Emergency (other than parent/guardian)

Name: _____ Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

TELEHEALTH CONSENT

I hereby voluntarily give my consent for my child listed below to receive telehealth services through the Harris County School District's School-Based Telehealth Program via Mercer Medicine for the purpose of healthcare service(s) and/or procedure(s). I authorize any physician or designated health/mental health professional working through the Harris County School District's School-Based Telehealth Program to provide care. I understand that additional consent will be obtained prior to each appointment. I understand that during the telehealth consult, details of my child's medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology. I understand that a physical examination may take place. I understand that a non-medical technician may be present in the telemedicine studio to aid in the video transmission. I understand that video, audio and/or photo recordings may be taken of the patient during the procedure(s) or service(s). I understand that all existing laws regarding access to my child's medical records apply to these telehealth consultations. Not all telecommunications are recorded and stored. Additionally, dissemination of any patient identifiable images or information for telemedicine interactions to researchers or other entities shall not occur without my consent. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during a telemedicine consultation. It is my right to withhold or withdraw consent to the telemedicine consultation at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I agree that any dispute arising from a telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes. Based upon this consent, I have been advised and understand all potential risks, benefits, and consequences of telemedicine. If necessary, I will have the opportunity to ask questions about the information presented in this consent and about the telemedicine consultation. I understand the written information provided above.

I agree for my child to participate in telemedicine consultations for the procedure(s) and/or service(s) described above.

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Signature _____ **Date** _____

Please list any adult(s), other than parents/ guardians, over the age of 18 who have permission to give consent for your child to participate in a telehealth visit if parents/guardians cannot be reached.

1. Name: _____ Relationship to Patient: _____

Home Number: _____ Cell Number: _____ Other: _____

2. Name: _____ Relationship to Patient: _____

Home Number: _____ Cell Number: _____ Other: _____

3. Name: _____ Relationship to Patient: _____

Home Number: _____ Cell Number: _____ Other: _____

I hereby voluntarily give my consent for the above listed person(s) to approve a school-based telehealth visit in the event that I cannot be reached. I understand that I may withdraw my consent for any of the above persons at any time by submitting a written statement to the school nurse or telehealth coordinator. I understand that any person(s) listed above will continue to have my consent to approve a telehealth visit until such signed and dated written statement is received.

Parent/Guardian Signature _____ **Date** _____

MEDICAL HISTORY

Name of Primary Care Physician _____

Address _____ Phone Number _____

Name of Dentist _____

Address _____ Phone Number _____

Name of any other Health Care Provider _____

Address _____ Phone Number _____

Name of Pharmacy _____

Address _____ Phone Number _____

List Medication Allergies

1) _____ 2) _____

3) _____ 4) _____

List All Medical Problems (Ex: Asthma, ADD/ADHD, Autism, Hypertension, etc.)

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

List all Previous Surgeries

1) _____ 2) _____

3) _____ 4) _____

Current Medication List (Include dosage and time)

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Family History (Ex: Hypertension, Cancer, etc.)

Mother _____

Father _____

Please list any religious/personal beliefs that may affect your child's care:

MEDICAL HISTORY(CONTINUED)

PLEASE MARK ALL THAT APPLY

ENDOCRINE

- ___ Swelling under arms or neck
- ___ Weakness and tiredness
- ___ Always hungry
- ___ Increased thirst
- ___ Increased urination
- ___ Tends to be too hot
- ___ Tends to be too cold
- ___ Frequent fever and chills
- ___ Night sweats
- ___ Problems going to sleep
- ___ Problems waking up after falling asleep

- ___ Recent weight gain
- ___ Recent weight loss
- ___ Diabetes
- ___ Other _____

INFECTIONS

- ___ Chicken pox
- ___ Hepatitis B
- ___ Hepatitis C
- ___ HIV/AIDS
- ___ Strep Throat
- ___ Other _____

PULMONARY

- ___ Chronic snoring

- ___ Persistent cough
- ___ Coughing up blood
- ___ TB (or exposure to)
- ___ Sleep apnea
- ___ COPD, emphysema or chronic bronchitis
- ___ Asthma
- ___ Other _____

NEUROLOGY

- ___ Frequent headaches
- ___ Migraines
- ___ Seizures
- ___ Stroke or paralysis
- ___ Memory problems
- ___ Meningitis
- ___ Nerve damage to feet/hands
- ___ Other _____

EARS, NOSE & THROAT

- ___ Wears glasses or contacts
- ___ Eye drainage
- ___ Blurry vision
- ___ Recent changes in vision
- ___ Decreased hearing
- ___ Earache or drainage
- ___ Ringing in ears
- ___ Allergies (Seasonal)
- ___ Sinus problems
- ___ Frequent nose bleeds
- ___ Frequent sore throat
- ___ Tongue/mouth sores

- ___ Goiter/thyroid problems
- ___ Neck pain or lumps
- ___ Any change in voice
- ___ Dental problems
- ___ Other _____

HEMATOLOGY

- ___ Anemia/low blood count
- ___ Sickle cell disease

- ___ Bleeding/bruising easily
- ___ Cancer (Please list _____)
- ___ Chemo/Radiation exposure
- ___ Other _____

MUSCULOSKELETAL

- ___ Frequent pain in fingers or hands
- ___ Muscle or joint pain
- ___ Leg cramps with exercise
- ___ Leg cramps at night
- ___ Arthritis
- ___ Other _____

GENITOURINARY

- ___ Frequent urination
- ___ Burning on urination
- ___ Difficulty starting urination
- ___ Incontinence
- ___ Kidney stones
- ___ Kidney disease
- ___ Other _____

CARDIOVASCULAR

- ___ Chest pain
- ___ Heart palpitations
- ___ Dizziness upon standing
- ___ Swelling in feet/hands
- ___ High blood pressure
- ___ High cholesterol
- ___ Fainting spells
- ___ Shortness of breath with exercise
- ___ Heart murmur
- ___ Other _____

GASTROINTESTINAL

- ___ Frequent heartburn
- ___ Decreased appetite
- ___ Frequent nausea or vomiting
- ___ Liver disease
- ___ Jaundice or hepatitis
- ___ Difficulty swallowing
- ___ Stomach pain
- ___ Recent change in bowel habits
- ___ Frequent diarrhea
- ___ Frequent constipation
- ___ Incontinence
- ___ Bloody stools
- ___ Rectal pain
- ___ Hemorrhoids
- ___ Rectal fissure
- ___ Parasites or worms
- ___ Pancreatitis
- ___ Other _____

BEHAVIORAL / MENTAL

- ___ Nightmares
- ___ Bedwetting
- ___ Eating problems
- ___ Thumb sucking
- ___ Discipline problems
- ___ Overactive/hyperactive
- ___ Shyness/social avoidance
- ___ Sleeping problems
- ___ Developmental delays
- ___ Learning disabilities
- ___ Depression
- ___ Anxiety
- ___ Cries often
- ___ Feels sad
- ___ Hears voices
- ___ Anger
- ___ Diagnosed behavioral/mental disorder (Please list _____)
- ___ Other _____

My signature indicates that all medical history is true and accurate to the best of my knowledge.

Parent/Guardian Signature _____

Date _____

AUTHORIZATION TO BILL INSURANCE

Please note that Harris County School District is not responsible for billing or for the collection of any associated fees for the services provided. Your insurance will be billed by the physician's office, and you will be responsible for copays, deductibles, or any other charges not covered by your insurance.

Patient's Name _____

Patient's Date of Birth _____ Patient's Social Security Number _____

Primary Insurance Company

Insurance Company _____ Person Insured _____

Insured's Date of Birth _____ Insured's Social Security Number _____

Policy or Member Number _____ Group Number _____

Secondary Insurance Company (if applicable)

Insurance Company _____ Person Insured _____

Insured's Date of Birth _____ Insured's Social Security Number _____

Policy or Member Number _____ Group Number _____

Responsible Party

Name _____ Date of Birth _____

Social Security Number _____ Employer _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED

Information on this form is protected health information (PHI) and is to be treated as confidential under HIPAA rules, privacy & security. All services are charged directly to the patient or the patient's representative and/or insurance company by the provider. Acknowledgement: I consent to the use of PHI for purposes of treatment, payment and operations. I authorize the entity to use the PHI as needed. I authorize that payment of benefits be made on my behalf directly to the provider. I understand that I am financially responsible for all charges not covered by insurance.

Parent/Guardian Signature _____ **Date** _____

HIPAA AND OUR PATIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 1996. The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of identifiable health information. This rule essentially controls the use and disclosure of what is known as Protected Health Information. We are required to provide you with the attached notice. We encourage you to read the information concerning our privacy practices. It is your copy to keep. *See attached HIPAA Notice.*

I acknowledge receipt of the HIPAA Notice of Privacy Practices from the **Harris County School District's School-Based Telehealth Clinic via Mercer Medicine.**

Parent/Guardian Signature _____ **Date** _____