Cincinnati Health Department

School-Based Health Center Enrollment Packet

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: _____ **DOB:** ___/___/____ **Gender: M/F Trans: MTF/FTM or Non-Binary**

Child's Social Security #: _____-_____-_____ Medical Card/Insurance ID: _____

☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ No Insurance ☐ OTHER _____

MEDICAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate). My child may be **TRANSPORTED/ACCOMPANIED** to and from medical services by a school designee. I, the parent or guardian of above-named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District (CPS), its board personal injury or damage resulting from the transportation of my student to and from health services. ***Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.***

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)

DENTAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

EYE CENTER SERVICES:

☐ **YES,** I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO**, I do not wish for my child to receive **VISION SERVICES**

⇨ _____ _____ _____

Parent / Guardian Signature (or patient if 18 or older) **Parent/Guardian Name** (PRINT) **DATE**

Phone (best) _____ Phone #2_____ Phone #3_____

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). **Consent in effect until terminated in writing** by Parent/Guardian.

STUDENT/PATIENT'S NAME: _____ **DOB:** ___/___/___

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security No.: _____

Address: _____ City/State/ZIP: _____

Emergency Contact Person: _____ Phone Number: _____

Your Child's Health History

❖ Do you have a **Primary Care Doctor**? ☐ YES ☐ NO

Doctor Name/Clinic: _____ Phone #: _____ Fax #: _____

Date of last complete yearly physical examination (head to toe): _____

❖ Do you have a **Primary Dentist?** ☐ YES ☐ NO

Dentist Name/Clinic: _____ Phone #: _____ Fax #: _____

Date of last routine dental check-up: _____

❖ Do you have a **Primary Eye Doctor?** ☐ YES ☐ NO

Eye Doctor Name: _____ Phone #: _____ Fax #: _____

Date of last routine vision exam: _____

❖ Do you have a **Preferred Pharmacy?** ☐ YES ☐ NO

Preferred **Pharmacy**: _____ Phone #: _____ Fax #: _____

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

****<u>SPECIAL NOTE</u>: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you <u>must</u> complete a CPS Administration of Medication form****

Has your child had any operations, serious injuries, or hospitalizations? ☐ No ☐ Yes

Please provide reason and dates: _____

Has your child ever been pregnant? ☐ No ☐ Yes If *Yes*, how many living children has your child given birth to: _____

Has your child been a victim of abuse? ☐ No ☐ Yes

Has anything bad, scary or sad happened to your family? ☐ No ☐ Yes

Please explain: _____

School Concerns: Explain any YES answers on the line provided.

Is your child in a special class (Special Ed / IEP / 504 Plan)? ☐ YES ☐ NO _____

Has your child repeated a grade? ☐ YES ☐ NO _____

Does your child get into trouble often at school? ☐ YES ☐ NO _____

What are your child's grades? _____ ***Is this a change?*** ☐YES ☐ NO

(Please continue to the next page)