Welcome to **TRC's SCHOOL BASED HEALTH CENTER**!

We welcome you to TRC's School Based Health Center, located at Jamestown High School. Our providers are: Nicole Hinderleider, NP and Adnan Munir, Medical Director. Dental Hygiene services are overseen by Jeffery Borst, DMD. Enclosed please find new patient paperwork that we need you to fill out prior to your enrollment.

The School-Based Health Center (SBHC) is like a doctor's office at the high school. The staff includes a Nurse Practitioner, a Registered Nurse, a Medical Assistant, Dental Hygienist and a Medical Director. The services that are available at the SBHC include:

- Physicals (Annual, Sports and Work Physicals)
- Immunizations
- Prescriptions for medications
- Assessment and treatment of chronic and acute illnesses like asthma, diabetes, sore throats, and coughs.
- Oral Screenings or referrals to dental services
- Mental Health screenings and referrals for counseling and other mental health services
- Dental appointments including: cleanings, treatment and sealants where available

It is easy to register your child for SBHC. The SBHC staff cannot see your child without written guardian consent. There are two papers to complete and your child is then enrolled until he/she graduates or leaves the school, or chooses to disenroll with written notice.

The SBHC does NOT take the place of your child's regular doctor or dentist, but rather works with your child's doctor and/or dentist to provide quality health care right in the school. If your child is up-to-date on their annual physical/dental exam, we encourage you to include a copy (along with immunizations) or request your doctor's office to please fax us a copy to: 716-661-4717.

There is NO out of pocket expense for the child or the family. We bill the child's insurance if he/she has insurance. If there is no insurance, **the staff will refer you to someone to help obtain insurance.**

The SBHC is open during regular school hours. We prefer appointments but walk-in's are always welcome.

We provide emergency after-hours on call service. However, this service is reserved for emergency concerns only. You may reach our on-call service at: 716-661-1447. If you have a question concerning a simple matter, an appointment time or medication refill, please call the morning of the next school day at 716-483-4373 and we will be happy to assist you.

Sincerely,

The Providers and Staff of TRC School Based Health Center

REGISTRATION FORM

School Based Health Center

TRC School Based Health Center at Jamestown Public Schools

Today's Date :				**How were you referred to our program?**	
PATIENT INFORMATION					
Student's last name: First Name: Middle:				Grade:	Social Security #:
Birth date:	Age:	Gender at Birth: ☐ M ☐ F	Phone #	Name of Parent/Legal Guardian:	
Street address:		P.O. Box	APT #	Relationship:	
City:		State	Zip	Preferred Pharmacy:	

Race (check boxes that apply): ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black /African American ☐ American Indian/ Alaskan Native ☐ White ☐ More than one Race ☐ Unreported/Refuse to Report

Ethnicity ☐ Hispanic ☐ Non Hispanic

INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other Insurance ☐ No Insurance

Primary Insurance Company:	Policy #	Group #:	Effective Date
Card Holder's Name:	Social Security Number	DOB	Employer & Phone Number
Secondary Insurance:	Policy #	Group #:	Effective Date
Card Holder's Name:	Social Security Number	DOB	Employer & Phone Number

Name of Student's Primary Care Doctor	**Primary Care Doctor's Phone #**
_____	_____

IN CASE OF EMERGENCY

We require the name, address, phone number and/or cell phone number of 2 contacts.

_____	_____	_____
(Name of First contact)	**(Address)**	**(Phone and/or Cell #)**
_____	_____	_____
(Name of Second contact)	**(Address)**	**(Phone and/or Cell #)**

Signature of Parent/Guardian :_____ Date:_____

School Based Health Center

Consent for Health Services Form

The following services will be provided to your child at the School-Based Health Center:

1) Comprehensive physical exams, including those for school sports and working papers
2) Lab test, when necessary, to detect illness or infection (i.e., strep throat)
3) Immunizations (age appropriate)
4) Assessment and treatment for acute and chronic conditions and acute injuries & illnesses
5) Prescriptions and medication administration
6) Referrals to an outside agency for services not provided at the School-Based Health Center
7) Nutrition counseling
8) Health education counseling
9) Mental Health Services

I hereby give consent for, _____ to receive health care services provided by the professional staff of the School-Based Health Center. I understand this consent expires when my child is no longer enrolled in the Jamestown Public Schools, or when a written statement is received.

I further give consent to the staff of the School Based Health Center to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, if necessary, you may contact our **Primary Care Provider** or any other healthcare providers to share information regarding my child's treatment and you may exchange medical information as needed with the school nurse for coordination of care purposes.

I further give consent to the staff of the School Based Health Center to obtain copies of my child's most recent physical exam and immunization records from their Primary Care Provider.

Your school nurse and the SBHC will review your child's records to determine which shots are needed. Please place an X by any immunizations you DO NOT want your child to receive.

School Required Immunizations:

☐ **DTAP/Td**	☐ **Polio**	☐ **MMR (Measles, Mumps, Rubella)**
☐ **Tdap**	☐ **Hepatitis B**	☐ **Meningococcal A**
☐ **Varicella (Chicken Pox)**		

Pediatric/Adolescent Recommended Immunizations:

☐ **Human Papillomavirus (HPV)**	☐ **Influenza (Flu)**	☐ **Hepatitis A**
☐ **Meningococcal B**	☐ **COVID**	

Please visit www.immunize.org/viz for more information on vaccines.

I hereby give consent to receive Comprehensive Physical Exam by the professional staff of the School Based Health Center.

I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier and made payable directly to The Resource Center - SBHC.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, reproductive health or outpatient mental health services.

All care provided will be in collaboration with your child's **Primary Care Provider**.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of The Resource Center Health Services Privacy Practices, Patient Bill of Rights, Patient responsibilities and Programs and Services available to me and my family.

The staff of the School-Based Health Center considers parental/guardian involvement very important. Accordingly, the staff will encourage every student to involve his/her parent/ guardian in counseling and medical care decisions. We encourage parents/ guardian to visit or call the Center at any time.

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

Relationship: _____

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of patient: _____

Signature of parent or guardian: _____

Date: _____

TRC SCHOOL BASED HEALTH CENTER

Patient's Bill of Rights

The Diagnostic and Treatment Clinical Service Program, a division of The Resource Center, ensures that each patient be entitled to the following rights:

1. To receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin, or sponsor.
2. To be treated with consideration, respect, and dignity, including privacy in treatment.
3. To be informed of the services available at the clinic.
4. To be informed of the provisions for off-hour emergency services.
5. To be informed of the charges for service, eligibility for third-party reimbursements and, when applicable the availability of free or reduced cost care.
6. To receive an itemized copy of his/her account statement, upon request.
7. To obtain complete and current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand.
8. To receive from his/her physician the information necessary to give informed consent prior to the initiation of any non-emergency procedure and/or treatment. An informed consent shall include, at a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care of treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision.
9. To refuse treatment to the extent permitted by law and to be fully informed of the consequences of such action.
10. To refuse to participate in experimental research.
11. To voice grievances and recommend changes in policies and services to the Clinic's staff, the governing authority and the New York State Department of Health without fear of reprisal.
12. To express complaints about the care and service provided and to have the Clinic investigate such complaints. The Clinic is responsible to providing the patient or his/her designee with a written response within 30 days if required by the patient, indicating the findings of the investigation. The Clinic is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the Clinic's response, the patient may complain to New York State Department of Health's Office of Health Systems Management.
13. To privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. To approve or refuse the release or disclosure of the contents of his/her medical record to any health care practitioner and/or health care facility except as required by law or third-party payment contract.
15. To access to his/her medical record pursuant to the provisions of Section 18 of the Public Health Law and Subpart 50-3 of this title.
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
17. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.