Enrollment in Health Services for the 2024/2025 School Year

Student Name:_____Date of Birth:_____

The HealthPoint School Based Health Center (SBHC) is easily accessible on school grounds where students can go for comprehensive preventive primary health care. The health services are provided by a Nurse Practitioner. Medical Services are provided onsite to your child(ren) at Tichenor Middle School and at Howell, Lindemann, Miles and Arnett Elementary Schools. All centers are open to all Erlanger-Elsmere School students.

Enrollment in the school based health services is optional. You can enroll at any time during the school year by calling your school nurse. You must complete the attached forms and return to your school to be enrolled.

Before receiving services the following paperwork must be completed and turned in to the school. Please note that these forms are required to be updated annually. Any incomplete forms will be returned to you.

Fees for Services:

- **Uninsured patients** will be billed **$23** per medical visit
- **Commercial patients** will be billed for your plan's cost sharing responsibility.
- **All Kentucky Medicaid plans** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date.

HealthPoint's Centers onsite at Covington Independent Schools can provide many services including:

- Well-child exams with immunizations
- Sports/School Physicals if your child has not had a Well-child exam in the past 12 months
- Sick visits and over-the-counter medications (i.e.: Tylenol, Advil, etc.)
- Write Prescriptions as needed for patients seen in the center
- Management of chronic illnesses

HealthPoint operates a full service clinic in the city of Florence at 7607 Dixie Highway. This location has Saturday and weekday evening hours and walk-in appointments that are accessible for your student, you and your family for health, dental, vision and mental health care. Phone number: 859-655-6100
Website: www.HealthPointfc.org

Permission Form for Health Services for the 2024/2025 School Year

Child Name:_____**Date of Birth**_____

I want to enroll my child in HealthPoint's services *(checkmark services you are enrolling)*

☐ **Medical:** well child visits, physicals, sick visits, medicine, immunizations

Sign your Initials next to each vaccine here for which you are consenting:

_____ Administer all Vaccines as required for school attendance (see box to the right)

_____ HPV (Human papillomavirus Vaccine) – 2 doses recommended for students age 11-14, 3 doses recommended for students age 15 and over

_____ Flu Vaccine

_____ Meningicoccal B – 2 doses recommended for ages 16-23 or children over age 10 at increased risk for Meningitis

Immunizations are Only Provided During a Medical Visit
Required for School Attendance for all ages

Dtap –4 doses	Varicella -2 doses
Polio –3 doses	Hepatitis A – 2 doses
Hepatitis B-3 doses	MMR -2 doses

Additional Requirements for Preschool and Kindergarten
Pneumococcal and Hib
Additional requirements for 6th Grade and Older
Meningitis and Tdap
Second dose of Meningitis required at age 16
Children on a catch up schedule may have different dose requirements based on age at time of vaccines administration.

If any of the vaccines in this box should not be given explanation here:

_____

CONSENT FOR TREATMENT

I certify all information in this packet is correct, and that my signature below constitutes my authorization for purposes of all statements and information contained in this packet. I hereby consent for my minor to have treatment including whatever test or procedures may be directed by HealthPoint's medical or dental provider. I also consent to all state-required immunizations, except where excluded above. I authorize HealthPoint Family Care, Inc. to bill me and my insurance for services rendered. I further authorize the release of my medical and dental information to my insurers and responsible party. I understand that I will be responsible for all bills if there is not active insurance. I authorize HealthPoint to release health records to the school as required for enrollment, including school physicals and immunization records. I understand it is my responsibility to notify HealthPoint if there are changes in insurance, guardianship, home address, or phone number. I understand that HealthPoint uses a single, shared medical record for all departments and offices, and therefore any visits and treatment your child has, including mental health and substance disorder treatment, is available to every HealthPoint provider caring for my child for any reason.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES to see HealthPoint's Privacy Policy and Nondiscrimination Notice. Go to www.healthpointfc.org or obtain a paper copy Compliance Office 215 E. 11th St.,Newport 859-655-6100. I acknowledge by signing below that I have access to the Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF VACCINE INFORMATION STATEMENTS

The Center for Disease Control also provides Vaccine Information Statements (VIS) which are information sheets that explain both the benefits and risks of a vaccine to vaccine recipients. You may view and print the current VIS at https://www.cdc.gov/vaccines/hcp/vis. You can also view and print immunization schedules to be aware of which vaccines your child should receive by visiting https://www.cdc.gov/vaccines/schedules I acknowledge by signing below that I have been made aware of where to obtain vaccine resources and the most recent Vaccine Information Statements prior to my child (or myself if over 18) being administered vaccines in the school-based health clinic.

Signature of Guardian (or Student if 18+) _____ **Date** _____ **Printed Name of Guardian**

Required Information Form for Health Services for the 2024/2025 School

Student Name:_____ **Date of Birth:**_____ **Male / Female**

Address:_____ **Social Security #:**_____

City/Zip:_____ **Preferred Language:** English____ Spanish ____

Parent Email Address:_____ **Othe Language write in here**:_____

Home Phone Number:_____ **Parent Cell Phone Number:**_____

Parent Work Phone:_____

You agree we may contact you by telephone at any telephone number associated with your account, including cell numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service.

Electronic Access to your Child's medical record is available by registering at healthpointfc.myezyaccess.com

Race (select all that apply): [ ] Asian [ ] White [ ] American Indian/Alaska Native [ ] Black/African American [ ] Other Pacific Islander [ ] Native Hawaiian

Ethnicity: [ ] Hispanic [ ] Non-Hispanic

Identifies as: [ ]Male [ ]Female [ ]Male to Female [ ]Female to Male [ ]Neither exclusively male or female [ ]Choose not to disclose

Sexual Orientation: [ ]Straight or heterosexual [ ]Lesbian, gay, or homosexual [ ]Bisexual [ ]Don't know [ ]Choose not to disclose

Your Relationship to Child: [ ] Parent [ ] Foster Parent [ ] Legal Guardian

PARENT/GUARDIAN INFORMATION: **BILLING TO INFORMATION:** Check here [ ] if same as Parent/Guardian

Name:_____ **Name:**_____

Address:_____ **Address:**_____

City/ Zip:_____ **City/Zip:**_____

HealthPoint is required to obtain Income information. This information is used to provide services at the fees quoted above. **Enter your household annual income** $ **Enter the # of People in the home** ☐

My child has (Check All That Apply) ☐ **No insurance** ☐ **Medicaid** MCO Name:_____ ID #:_____

☐ **Private medical insurance I**D #:_____ Group # :_____

My school is: _____ Lloyd ____ Tichenor ____ Howell ____ Lindemann ___ Miles ____ Arnett

Required Information Form for Health Services for the 2024/2025 School

Student Name:_____ **Date of Birth:**_____

Student's Current Primary Care Provider:_____ **Providers' Phone #:**_____

Student's Current Dental Provider:_____ **Providers' Phone #:**_____

Answers to Following Questions are required to provide care for your student.
The name of the person providing the answers to these questions: Print Name Here:_____
Relationship to patient: ( )Mother ( )Father ( )Grandmother ( )Grandfather ( )Caretaker ( )Other - _____

Social History:

Child's parents are:
( ) married and living together
( ) separated not living together
( ) divorced not living together
( ) other:_____

Who is the Primary Caretaker:
( ) mother
( ) father
( ) grandmother
( ) grandfather
( ) other - _____

Custody Arrangements:
( ) mother is the custodial parent with standard visitation with father
( ) father is the custodial parent with standard visitation with mother
( ) parents have joint custody with shared parenting time
( ) mother is the custodial parent with little or no visitation with father
( ) father is the custodial parent with little or no visitation with mother
( ) grandparents have custody of the child
( ) foster care
( ) other - _____

How is the child doing in school? ( ) well ( ) poorly or not well
Absent from school this year # _____ of ( ) days ( ) weeks ( ) months

Does the child live in a home built before 1970? ( ) Yes ( ) No
Does anyone who lives with the child smoke? ( ) Yes ( ) No
If yes, whom? ( )mother ( )father ( )grandmother ( )grandfather ( ) Other
Has the child ever been physically abused? ( ) Yes ( ) No
Has the child ever been sexually abused? ( ) Yes ( ) No
Is there a gun in the home? ( ) Yes ( ) No If yes, is the gun stored in a secure, locked location? ( ) Yes ( ) No
Does the child smoke, use smokeless tobacco or vape? ( ) Yes ( ) No
If yes provide the following ( ) Cigarette Amount ____ pack(s) per #___ ( ) day ( ) week for #___years
( ) Smokeless Amount ____ can(s) per #___ ( ) day ( ) week for #___years
( ) Vape Amount ____ cartridge(s) per #___ ( ) day ( ) week for #___years
Any concerns about drugs or alcohol? ( ) Yes ( ) No

Family History of: (Please check all that apply)

( ) Alcohol/Drug Abuse	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Asthma	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Cancer	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Stroke	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Diabetes	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Heart disease	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Heart attack before age 50	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) High Blood Pressure	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) High Cholesterol	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Lead poisoning	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Mental Illness	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Seizure or epilepsy	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Sickle Cell	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Suicide	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Thyroid Disease	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother
( ) Other:_____	( ) mother ( ) father ( ) brother/sister ( ) grandfather ( ) grandmother

Required Information Form for Health Services for the 2024/2025 School

Student Name:_____ **Date of Birth:**_____

Family Health:

Mother's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Father's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Guardian's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Sibling's Name:_____Age:___Living with child? ( ) yes ( ) no Health: ( ) Healthy ( ) Sick ( ) Deceased

Child's Medical History:

Does your child have any allergies? If yes, list all allergies and reactions (examples -medicines, pollens, food, stinging insects):

( ) Yes ( ) No_____

List past and current medical conditions: _____

_____

Has your child 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):

_____

_____

What pharmacy does the child use?_____City and Phone #:_____

Is your child seeing a specialist? ( ) no ( )yes – please explain:_____

Do you have any medical concerns for your child? ( ) no ( )yes – please explain: _____

Do you have any dental concerns for your child? ( ) no ( )yes – please explain:_____