Trojan Health Center

Located at Sparta School
450 N Main Street
Sparta, NC 28675
Phone: (336) 372-5641 ext. 1200
Email: sbhc@apphealth.com

August 11, 2025

Dear Parent/Guardian,

Welcome back to school, Alleghany County School families!

The Trojan Health Center is a school based health center located at Sparta School that provides comprehensive, coordinated healthcare at school – a trusted place where students spend a lot of their time. Services provided by the center include: acute care (coughs, colds, runny noses, etc.), strep and flu testing, hemoglobin and glucose testing, yearly well checks, sports physicals, vision and hearing screens. We also provide behavioral health and nutrition services for students. In addition, if your child is not under the care of a dentist on a regular basis, AppHealthCare's portable dental clinic will be providing dental services this school year.

The Trojan Health Center is staffed by a Family Nurse Practitioner, Registered Nurse, Management Support Specialist and a Behavioral Health provider. We work closely with the AppHealthCare leadership team, including AppHealthCare's Medical Director, for services provided.

We are here to provide health care services for your child during the school day. This prevents your child from having to leave school for a doctor appointment and allows you to remain at work during the day. We do not take the place of your primary medical provider and you do not have to change doctors to utilize our services. We provide care in addition to your child's primary medical provider and send them updates about treatment your child receives.

If you are interested in having your child receive services at the Trojan Health Center, please complete this enrollment packet entirely and include a copy of your child's health insurance card, if applicable. We are happy to make a copy of your child's insurance card at the Health Center if you prefer. Rest assured, you will not be billed for any copays at the Trojan Health Center. We look forward to working with you this school year to provide optimal care for your child. If you have any questions, please feel free to call the center at (336) 372-5641 ext. 1200 or email us at sbhc@apphealth.com.

Thank you for allowing us to provide important healthcare services to your child.

Sincerely,

Trojan Health Center Staff

STUDENT PATIENT REGISTRATION

School Based Health Center – Trojan Health Center
Student Registration Form
2025-2026 School Year

Child's First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Gender (select one): ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

County: _____ Student Grade: _____ Student School: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method (select one): ☐ Home Phone | ☐ Work Phone | ☐ Cell Phone | ☐ Text Message (charges may apply)

Parent Name: _____ Parent SSN# or ITIN#: _____

Parent Email: _____ Homeroom Teacher: _____

Race (select all that apply):	**Ethnicity (select all that apply):**	**Housing (select all that apply):**
☐White	☐Hispanic Latino	☐Not homeless
☐Black, African American	☐Non-Hispanic Latino	☐Homeless
☐Asian	☐Decline to answer	☐Decline to answer
☐Native Hawaiian		
☐Other Pacific Islander		
☐American Indian or Alaska Native		
☐More than one race		
☐Unknown or decline		
☐Other		

Preferred Language (select): ☐ English | ☐ Spanish | ☐ Other Language:_____

Country of Origin: _____

Emergency Contact Name (if different than parent/guardian)	**Emergency Phone Number** (NOT patient phone number)	**Relationship to Patient**

Last Updated: 07/2025

Date of Last Complete Physical: _____ If date unknown, check here: ☐

Patient Healthcare Information - This information is used to send visit information to your primary care provider.

Primary Care Provider Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

If you do not have a dentist, would you like to be referred to the AppHealthCare Dental Health Center?
☐ Yes, I prefer my child be seen at school. ☐ Yes, please call me to make an appointment.

Preferred Hospital: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Please list all medications and doses your child is currently taking:

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Insurance Information ***Please include a copy of your insurance card if possible***

Insurance Name (Primary Policy): _____

Policy Number: _____ Group Number: _____
(Policy and Group # not required if copy of insurance card is provided.)

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Effective Date of Insurance: _____

Parent/Guardian Information
Mother/Guardian Name: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father/Guardian Name: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

_____ _____

Parent/Guardian Signature **Date** **Witness (clinic staff)** **Date**

CONSENT FOR SERVICE

I consent for the School Health Center providers designated by AppHealthCare to provide or arrange services to meet the needs of myself/my child. These services may include any or all of the following:

- Medical evaluation, including history, physical examination, and routine office laboratory tests
- Treatment of injuries and illness, including any necessary prescriptions other than pain medications
- Counseling, assessment, consultation, and referral to appropriate services
- Substance abuse (tobacco) prevention and intervention
- Social Work services or referral
- Nutritional guidance

Confidential Services
I understand that North Carolina General Statute 90-21.5 protects a minor's right to receive services related to sexually transmitted disease, pregnancy, drug abuse, and emotional disturbance without parental consent. I understand that medical providers are not allowed to notify the parent/guardian about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I further understand that the Health Center staff will make every effort to encourage my child to discuss problems and services with me.

For services not designated as confidential, I understand that I will be informed and will be asked to authorize my child's treatments other than medical or over-the-counter treatments. In the event my minor child requires urgent medical care and I cannot be reached, I request that my child be allowed to authorize his/her own care with the understanding that I will be contacted as soon as possible. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL ASPECTS OF MEDICAL CARE IF FOLLOW-UP OR REFERRAL TO ANOTHER PROVIDER IS RECOMMENDED.

Access to Services 24 hours a day/7 days a week
The Trojan Health Center operates from 7:30 a.m. to 4:00 p.m. Monday through Friday, when school is in session. I understand that if my child needs medical attention after hours that I should contact my primary care provider first. I understand that if my child has a life threatening emergency, I am to take him/her directly to the emergency department or call 911. If my child has a mental health emergency, I understand to contact Daymark Community Mental Health Mobile Crisis Hotline at (866) 275-9552.

Medical Records Confidentiality
I give permission for information in the medical record to be shared with my primary care provider in order to coordinate care. In order to protect the confidentiality of the services provided through the Health Center, I request that my child's record be kept confidential and not be released, except as authorized, to me or anyone else without my/my child's consent. I understand that my child's record is the property of AppHealthCare and that the information within will be kept confidential in accordance with state laws and accepted medical practice.

Release of Information for Payment
I give permission for information in medical records to be used for billing third party payers, such as Medicaid or other insurance and for program management and evaluation purposes on a strictly confidential basis in accordance with the law and acceptable medical practice. This consent to release information authorizes AppHealthCare to release to any third payer indicated to be responsible for payment for this period of treatment and release of information from my health record, or any other information, to verify eligibility and confirm benefits, and secure payment of charges, both during and after my visit.

Assignment of Insurance Benefits
I hereby authorize payment directly to AppHealthCare of insurance benefits otherwise payable to me including medical and surgical benefits, not to exceed the reasonable and customary charge for these services rendered by said facility. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions whereby coverage is subject to a coordination of benefits clause.

Medicaid Patient Certification
I certify that the information given by me in applying for payment under Medicaid guidelines and Title XIX of the Social Security Act is correct and request that payment of authorized benefits be made on my behalf

Validity
This authorization is valid for the length of time necessary to process claims for the incurred charges. This consent to treatment and care shall remain effective until the student departs from the school or age 22, unless sooner revoked in writing and delivered to the Health Center.

I understand that by signing this document I authorize my child to receive services offered by the Health Center, including diagnosis, treatment, counseling, and dietitian services.
*I understand that I may revoke this consent at any time.
*I understand that I may decline any services either by verbal or written request to the staff at the Health Center.
*I understand that this consent is voluntary and valid for the entire time that my child is enrolled in Alleghany County Schools, provided that I give up-to-date medical insurance and registration information each school year or as needed.

By signing this statement, I confirm that I have received, read, and understand the following documents:

1. Registration and Consent for Services Forms
2. Billing, Insurance, and Collection Consent Policy
3. Parents & Students Rights and Responsibilities
4. Notice of Privacy Practices

_____

Signature of Parent/Legal Representative Date

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

General Medical History

1. **Do you consider your child to be in good health?**
   ☐ Yes ☐ No ☐ Do not know

   If no, explain:

   _____

2. **Does your child have any serious illnesses or medical conditions?**
   ☐ Yes ☐ No ☐ Do not know

   If yes, explain:

   _____

3. **Has your child had any surgery?**
   ☐ Yes ☐ No ☐ Do not know

   If yes, explain:

   _____

4. **Has your child ever been hospitalized?**
   ☐ Yes ☐ No ☐ Do not know

   If yes, explain:

   _____

5. **Is your child allergic to medicines or drugs?**
   ☐ Yes ☐ No ☐ Do not know

   If yes, explain:

   _____

6. **Do you feel your family has enough food to eat?**
   ☐ Yes ☐ No ☐ Do not know

   If no, explain:

   _____

Trojan Health Center: School Based Healthcare Center (SBHC)

Alleghany County Schools Authorization for Use and Disclosure of Protected Health Information

This form implements the requirements for student authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42CFR, part 2) and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (GS 122C).

I hereby authorize **Trojan Health Center/AppHealthCare Licensed Professional Providers** to disclose and/or share Protected Health Information with: **Alleghany County Schools.**

The following protected information: (provide a specific and meaningful description of the information to be used or disclosed)
Psychological evaluation results, Comprehensive Clinical Assessment documentation, Treatment plans, Progress notes, medical records, student status, participation in services, progress made, family dynamics and history, safety issues, recommendations, school status, school concerns, grades, testing, behavioral concerns, school progress, treatment plan, clinical impressions, substance use/abuse issues, treatment, and history.

The Purpose of Disclosure:
Coordination of services, participation in the School-Based Therapy and Trojan Health Center Programs, and treatment planning.

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), it must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

EXPIRATION AND REVOCATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. If not revoked earlier, this authorization expires automatically one year from the date it is signed.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. A readable photocopy or fax of this authorization shall have the same force and effect as this original.

SIGNATURES

Signature of Legally Responsible Person: _____ Date: _____

Specify Relationship to Student and Print Name in Full: _____

Signature of Student: _____ Date: _____

Additional Parent/Guardian Signature: _____ Date: _____

MENTAL HEALTH RESOURCE INFORMATION

*For a medical or mental health emergency, dial 911.

Local & National Resources	
AppHealthCare After-Hours Nurse	(336) 372-5641
Daymark Mobile Crisis Hotline (Available 24 hours per day)	1 (866) 275-9552
Vaya Crisis Hotline (Available 24 hours per day, 7 days a week)	1 (800) 849-6127
National Suicide & Crisis Lifeline	Call or text 988 or chat at 988lifeline.org
Alleghany Health (hospital)	(336) 372-5511
Alleghany County Sheriff's Office	(336) 372-4455
DANA (Domestic Abuse is Not Acceptable) Services	Crisis Line: (336) 372-3262 Toll Free: (866) 261-3262
LGBTQ Trevor Lifeline	(866) 488-7386

Last Updated: 07/2025