City of Cincinnati Primary Care (CCPC)

# School-Based Health Center (SBHC) Consent/Enrollment Packet

**PLEASE COMPLETE AND SIGN ALL PAGES**

STUDENT/PATIENT'S NAME: _____

DOB: _____/_____/_____ Child's Social Security #:---------- _____ Gender: _____

**Choose the race category below that best fits for the patient listed on this form. If the patient is more than one race, check all that apply.**

____ AL -Alaskan Native ____ AM-American Indian (including American Indians of Latino/Hispanic decent) ____AS-Asian
____ B- Black/African American (including Black/African Americans of Latino/Hispanic decent) ____Latino/Hispanic
____ N-Native Hawaiian ____PAC-Pacific Islander ____ PAT-Patient Refused ____U-Unknown
____W-White (including Whites of Latino/Hispanic decent)

Medical/Card/Insurance ID: _____ ☐Anthem ☐AmeriHealth ☐ Buckeye ☐ CareSource

☐ Humana ☐ Molina ☐ 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 SERVICES at the SBHC

**CCPC SBHC SITES**: Academy of World Languages (AWL), Aiken, Children's Home of Cinti (Best Point), Deaconess (Dater HS/Western Hills HS), Ethel Taylor, JP Parker, Mt. Airy, Oyler, Riverview, Roberts, Roll Hill, Taft HS, and Withrow HS

**DENTAL HEALTH CARE SERVICES:**

☐ YES, I consent for my child to receive DENTAL SERVICES at a Cincinnati Health Department (CHD) School-Based Dental Program 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

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**EYE CENTER SERVICES:**

☐ YES, I consent for my child to receive EYE CENTER SERVICES at the 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

**PLEASE REVIEW & COMPLETE BELOW**

_____

**(Signature)** Parent /Guardian (or patient if 18 or older) **(Print)** Parent/Guardian Name Date

Phone (best) _____ Phone #2_____

_____

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 the Program Description form (attached). The consent is in effect until terminated in writing by Parent/Guardian.

# City of Cincinnati Primary Care School-Based Health Centers

Summary of Patient Rights and Responsibilities, Information Sharing, and Financial Disclosure

At the School-Based Health Center ("SBHC"), all students have access to medical, dental, and vision care. With your consent, your child/adolescent can be seen at the SBHC during the school day for illness, check-ups, sports physicals, immunizations, dental services, or vision exams. This page includes a summary of students' rights and the SBHC's privacy practices. A more detailed explanation of the SBHC's privacy practices is available upon request.

Student Rights:

- **Respectful and Dignified Care:** The right to be treated with respect, courtesy, and consideration for their personal values, cultural beliefs, and individual preferences.
- **Privacy and Confidentiality:** The right to have their personal and health information kept private and protected in accordance with applicable laws and regulations.
- **Participation in Care Decisions:** The right to be involved in decisions about their care to the fullest extent possible
- **Freedom from Discrimination:** The right to receive care free from discrimination based on race, color, religion, gender, sexual orientation, disability, or other factors.

Student Responsibilities:

- **Adherence to Treatment Plans:** Students should adhere to the recommendations and the plans provided by their healthcare providers.
- **Seeking Help When Needed:** Students should seek help from SBHC staff or other trusted adults when experiencing physical, emotional, or mental health challenges.
- **Involvement in Their Care:** Students should actively participate in their healthcare decisions and take an active role in managing their health conditions.
- **Understanding Privacy Policies:** Students should understand the privacy policies of the SBHC and their rights regarding the protection of their health information.

Regarding Payment for Services:

- **No child will be denied care based on inability to pay for services.**
- If your child does not have health insurance, you may be asked to provide household income information. This is used solely to meet federal requirements and to determine eligibility for reduced or waived fees according to the sliding fee scale adopted by City of Cincinnati Primary Care. All information will be kept strictly confidential.
- If your child is uninsured, you may receive a bill for services at the appropriate discounted rate based on the information provided. A copy of these rates can be provided upon request.

Regarding Sharing of Health Information:

- The SBHC may review and/or request medical records or information from other healthcare providers or facilities where your child has previously received care.
- Visit summaries or results from SBHC appointments may be shared with your child's primary care provider to support continuity of care.
- Mental health resources are available through the school. If mental health services are recommended, the SBHC provider may initiate a referral to the school's mental health team. A representative will contact you to obtain consent before any services are provided. All information will be handled with strict confidentiality.

I have the right to receive or review a copy of the SBHC's **Notice of Privacy Practices**.
I acknowledge that I have been offered a copy of the Notice of Privacy Practices and that:

☐ I have received or reviewed a copy of the Notice of Privacy Practices; ***or***

☐ I do not wish to receive or review a copy of the Notice of Privacy Practices.

**Scan here to view the Privacy Practices online**

_____

Signature Date

city of CINCINNATI PRIMARY CARE

# SCHOOL BASED HEALTH CENTER INCOME ELIGIBILITY

**SECTION 1: Student Information**

Student Name: _____ Date: _____

School Attending: _____

**SECTION 2: Insurance Information**

Medical/Card/Insurance ID: _____ □ Anthem □ AmeriHealth □ Buckeye □ CareSource

□ Humana □ Molina □ United Health Care □ No Insurance □ Other _____

**SECTION 3: Income Eligibility** (List the **Names** and **Schools** of your other children who attend Cincinnati Public Schools, if any)

| | Student Name | School Attending |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

For additional children in different school districts, or not of school age, please add that information to the number of children in the household.

| | |
|---|---|
| Number of Adults in the Household | |
| Number of Children in the Household + | |
| Total Household Size (THH) = | |

**Example: If your total household size was 3 and your annual income was $35,000, you would find and circle the range in one of the columns titled (A, B, C, D, E).**

**Ex: Column "C"**

| | |
|---|---|
| 31,076 | 37,290 |

**2025 sliding fee discount based on Federal Poverty Guidelines. Circle Total Household Size and Income Range on chart below:**

| | A | | B | | C | | D | | E | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Size** | **Nominal Fee** | | **75% Discount** | | **50% Discount** | | **25% Discount** | | **Full Pay** | |
| 1 | 0 | 15,660 | 15,661 | 19,563 | 19,564 | 23,475 | 23,476 | 27,388 | 27,389 | & over |
| 2 | 0 | 21,150 | 21,151 | 26,438 | 26,439 | 31,725 | 31,726 | 37,013 | 37,014 | & over |
| 3 | 0 | 26,650 | 26,651 | 33,313 | 33,314 | 39,975 | 39,976 | 46,638 | 46,639 | & over |
| 4 | 0 | 32,150 | 32,151 | 40,188 | 40,189 | 48,225 | 48,226 | 56,263 | 56,264 | & over |
| 5 | 0 | 37,650 | 37,651 | 47,063 | 47,064 | 56,475 | 56,476 | 65,888 | 65,889 | & over |
| 6 | 0 | 43,150 | 43,151 | 53,938 | 53,939 | 64,725 | 64,726 | 75,513 | 75,514 | & over |
| 7 | 0 | 48,650 | 48,651 | 60,813 | 60,814 | 72,975 | 72,976 | 85,138 | 85,139 | & over |
| 8 | 0 | 54,150 | 54,151 | 67,688 | 67,689 | 81,225 | 81,226 | 94,763 | 94,764 | & over |
| 9 | 0 | 59,650 | 59,651 | 74,563 | 74,564 | 89,475 | 89,476 | 104,388 | 104,389 | & over |
| 10 | 0 | 65,150 | 65,151 | 81,438 | 81,439 | 97,725 | 97,726 | 114,013 | 114,014 | & over |
| 11 | 0 | 70,650 | 70,651 | 88,313 | 88,314 | 105,975 | 105,976 | 123,638 | 123,639 | & over |
| 12 | 0 | 76,150 | 76,151 | 95,188 | 95,189 | 114,225 | 114,226 | 133,263 | 133,264 | & over |
| | **0-100%** | | **101-150%** | | **151-175%** | | **176-200%** | | **>201%** | |

Signature: _____

By signing this line, you agree that the above information completed is accurate.

**Health Center Staff**: Please verify signature. Then enter the Total Household Size and Income Range in the FPL section of EPIC based on the amount circled above. Also, upload the Eligibility form into Documents file under SA63 financial, which must be updated every calendar year. If section 3 is NOT completed, update the financial record accordingly.

city of CINCINNATI PRIMARY CARE

Date_____

# Health History - 2025-2026

| Student's Name | Date of Birth | ____/_____ Grade/Homeroom |
|---|---|---|
| Doctor's Name | Phone Number | Last checkup or visit |
| Dentist's Name | Phone Number | Last checkup or visit |
| Preferred Pharmacy | Phone Number | Address & Zip |

## Any history of the following problems? (Circle Y for YES or N for NO)

| History For Student and then Family | Student | Family |
|---|---|---|
| Allergies: Seasonal/Hay fever | Y N | Y N |
| Life Threatening Allergy to:_____<br>EpiPen prescribed | Y N<br>Y N | |
| ADD/ADHD | Y N | Y N |
| Anemia or Other Blood Problems | Y N | Y N |
| Asthma | Y N | Y N |
| Behavioral Problems _____ | Y N | Y N |
| Blood Pressure Problems (High/Low) | Y N | Y N |
| Developmental Problems | Y N | |
| Cancer – type | Y N | Y N |
| Chronic Diarrhea or Constipation | Y N | Y N |
| Chronic Ear Infections | Y N | |
| Depression | Y N | Y N |
| Diabetes | Y N | Y N |
| Drugs or Alcohol Used During Pregnancy | Y N | |
| Eczema/Chronic Skin Condition | Y N | Y N |

| History For Student and then Family | Student | Family |
|---|---|---|
| Emotional/Psychological Problems | Y N | Y N |
| Frequent Headaches<br>Head Injury/Concussion?<br>When | Y N<br>Y N | Y N |
| Frequent Stomachaches | Y N | Y N |
| Hearing Problems | Y N | Y N |
| Heart Disease – type _____ | Y N | Y N |
| Kidney Disease – type _____ | Y N | Y N |
| Learning Problems _____ | Y N | Y N |
| Prematurity or Birth Weight under 5 lb. | Y N | |
| Seizure Disorder/Epilepsy/Tics | Y N | Y N |
| Sickle Cell Disease | Y N | Y N |
| Sleep Problems | Y N | Y N |
| Speech Problems | Y N | Y N |
| Toothaches/Dental Problems | Y N | Y N |
| Problems with Vision<br>Wears Glasses | Y N<br>Y N | Y N |
| Surgery? What type?_____ | Y N | |

**INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE**

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

**Facts for consideration:**

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

**Benefits of SDF treatment:**

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs patients that may require sedation for extensive dental care.

**Risks related to SDF:**

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidently applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

**Alternatives to SDF, not limited to the following:**

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

*I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.*

Patient Name: _____ Date of Birth:_____

Patient/Guardian Signature:_____ Date:_____

CHD Dental Staff Signature: _____ Date:_____

# Consent for Nitrous Oxide Sedation

**Patient Name:_____**

**If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.**

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections ("Novocaine"). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be "asleep" and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

⇨ _____

Signature (Parent/Guardian) Phone Number Date