Crossroad Health Center & Taft Elementary/MAPA

Welcome & Enrollment Packet

School Based Health Center at Taft Elementary

STUDENT/PATIENT Name: _____ **Date of Birth** ___/___/___ **Male/Female**

Child's Social Security # _____-_____-_____ Insurance ID: _____

Insurance: ☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ NO INSURANCE ☐ OTHER_____

Services Available through your School-Based Health Center

PRIMARY HEALTH CARE from Crossroad Health Center Provider at Taft Elementary:

YES, I consent for my child to receive MEDICAL CARE.

*May include treatment for acute illness or injury that occurs at school, referral to medical specialists, and may include administering over-the-counter medications unless emergency services are needed. SBHC care also includes routine well-child care (e.g. work, daycare, and sports physicals), and appropriate immunizations. (Note: well-child care includes vision / hearing screening, urine / blood tests, and an external genital exam, when appropriate.) ***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 from a Cincinnati Health Department (CHD) Clinic, affiliate or mobile clinic.

*May include preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals. Most care will occur at school, however, some services may require transportation to an outside clinic. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, 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

VISION CLINIC SERVICES:

YES, I consent for my child to receive EYE CLINIC SERVICES at the OneSight Vision Center at Oyler School.

*Services may include comprehensive eye examinations including dilation, vision therapy, and the fitting / dispensing of vision correction. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, 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 **Parent/Guardian Name** (PRINT) **DATE TODAY**

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

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I agree to terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have the option to review both the CHD and Crossroad's **Notice of Privacy Practices,** available at the nurse's office. **Consent in effect until terminated in writing** by Parent/Guardian.

WHY do we have a School Health Center & Nurse Practitioner?

We want to HELP:

- Keep your child out of the *emergency room* – unless absolutely necessary.
- Provide medical care – including diagnosis and prescriptions—if your child is sick at school.
- Reduce the trouble and time involved in taking your child to a doctor or urgent care.

Do you NEED a REGULAR DOCTOR for your children? We can help. Crossroad's Nurse Practitioner (NP) at Rothenberg can become your child's regular medical provider. This means your children can also be seen at the Crossroads Health Center, 5 E. Liberty Ave. in Over-the-Rhine, -- even when school is not open.

You are welcome to **KEEP your child's regular doctor.** The NP at school will communicate all care directly to your usual doctor.

Crossroad School-Based Health Center (SBHC) will **TRY TO CONTACT YOU immediately** if your child becomes sick or injured at school. Our medical staff will take appropriate action to keep your child safe and healthy during school hours. Please **NOTIFY SCHOOL** when you **CHANGE** phone numbers.

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

Parent/Guardian Name: _____ Relationship to child: _____

Parent/Guardian's Date of Birth: _____/_____/_____ Your Social Security No: _____- _____- _____

Address:_____ City/State/ZIP_____

Phone Numbers to reach you: (1)_____ (2) _____ (3) _____

· **Emergency Contact Person:**_____ Phone(s):_____

PLEASE inform School Nurse or Office when you CHANGE PHONE NUMBER! We must be able to reach YOU in an Emergency.

· Regular **Medical Doctor** or Clinic: _____ Child's last "well child" exam: _____

· Regular **Dentist**/Clinic: _____ Date of last check-up: _____

· Preferred **Pharmacy:** _____

Do you want a copy of the physical exam to go to your clinic or doctor? □ **YES** □ **NO**

Your Child's Health History

1. **Is your child allergic to ANY medications?** □ No □ Yes Please list: _____
2. **Any SEVERE food or environment allergies?** Please list: _____
   *Does your child have an **Epi-Pen** for this allergic reaction?* □No □Yes
3. **Did your child have any of these problems?** □ Prematurity or birth weight under 5 lbs. □ Difficult delivery □ Poor/slow growth in infancy
4. **Does your child TAKE any medications NOW? or IN THE PAST?** □Yes Please provide name of medication and condition.

   _____
5. **Has your child had any operations, serious injuries, or hospitalizations?** □ Yes Please provide reason and dates.

   _____
6. **Has your child ever been pregnant?** □ No □ Yes If ***Yes***, how many living children has your child given birth to: _____
7. **Has your child been a victim of abuse?** □ No □ Yes

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

Does your child have any LEARNING PROBLEMS?	□ YES	□ NO	_____
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

Does your CHILD or any FAMILY MEMBER have or had any of these HEALTH problems? (Please Check)

	CHILD	FAMILY		CHILD	FAMILY		CHILD	FAMILY
Asthma or wheezing	_____	_____	ADHD / Behavior	_____	_____	Allergies / Hay Fever	_____	_____
Cancer (type)	_____	_____	Concussion	_____	_____	Depression / Mental Illness	_____	_____
Diabetes	_____	_____	Drug / Alcohol Use	_____	_____	Eczema / Skin Problems	_____	_____
Headache / Migraines	_____	_____	Hearing Problems	_____	_____	Heart Disease	_____	_____
High Blood Pressure	_____	_____	Nosebleeds	_____	_____	Seizures	_____	_____
Sickle Cell Disease / Trait	_____	_____	Stroke	_____	_____	Urinary Tract Infections	_____	_____
Poor Vision / Blindness	_____	_____	Wetting/soiling self day or night	____	_____			

Other health concerns you may have about your child:

Tuberculosis (TB) Risk Assessment: Is your child in contact with any of the following persons: immigrants from another country, someone diagnosed or treated for TB, incarcerated children or adults, HIV-infected, homeless, nursing home residents, illegal drug users, or migrant farm workers? YES NO

Please **circle YES or NO** below.

Diagnosed or treated for TB?	YES	NO	Is an immigrant?	YES	NO
Traveled to another country?	YES	NO	Has ever been in jail or 20/20?	YES	NO