City of Cincinnati Primary Care (CCPC)

School-Based Health Center (SBHC) Consent & Enrollment Packet

PLEASE COMPLETE AND SIGN ALL PAGES (PRINT)

STUDENT/PATIENT'S NAME: _____

DOB: ____/____/_____Student/Patient 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 _____

CCPC SBHC MEDICAL 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

MEDICAL HEALTH CARE SERVICES:

☐ YES, I consent for my child to receive MEDICAL HEALTH 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 check 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 CCPC SBHC sites

CCPC SBHC DENTAL SITES: Academy of World Languages (AWL), Aiken, Deaconess (Dater HS/Western Hills HS), Oyler, Roberts, and Withrow HS

DENTAL CARE SERVICES:

☐ YES, I consent for my child to receive DENTAL CARE 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 CARE SERVICES at the CCPC dental sites

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CCPC SBHC VISION SITES: Academy of World Languages (AWL) and Oyler

EYE (VISION) CENTER SERVICES:

☐ YES, I consent for my child to receive EYE (VISION) CENTER SERVICES at a Cincinnati Health Department (CHD) School-Based Vision Center which may include comprehensive eye examinations including dilation, vision therapy, and fitting and dispensing for 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 EYE (VISION) CENTER SERVICES at the CCPC vision sites

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

Parent/Guardian Social Security#:_____

Parent/Guardian DOB:_____/_____/_____

Emergency Contact (not a parent or guardian)_____

Emergency Contact Phone # _____

I give consent for my child to obtain the services that I have marked in the boxes above. I agree with the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in the Summary of Patient Rights and Responsibilities, Information Sharing, and Financial Disclosure form (p.3) and Sliding Scale Discount Program form (p.4).

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, work physicals, immunizations, dental services, or vision exams. This page includes a summary of students' rights and CCPC privacy practices. A more detailed explanation of our 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 the 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 for the student 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 **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.

_____

Signature Date

Scan here to view the Privacy Practices online

City of Cincinnati Primary Care
2026 Sliding Fee Discount Program
Effective Date: February 12, 2026

Purpose:
The board approved Sliding Fee Discount Policy is the policy and procedure guiding the organization's establishment and implementation of the Sliding Fee Discount Program (SFDP). The policy states that the City of Cincinnati Primary Care will base the SFDP on the most current Federal Poverty Guidelines, (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines).
This document provides the Sliding Scale for 2026.

Use the charts below to determine your household size and your sliding fee discount percentages.

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"

34,151	40,980

Circle Total Household Size and select Income Range on chart below:

	A		B		C		D		E	
Size	**Nominal Fee**		**75% Discount**		**50% Discount**		**25% Discount**		**Full Pay**	
1	0	15,960	15,961	19,950	19,951	23,940	23,941	27,930	27,931	& over
2	0	21,640	21,641	27,050	27,051	32,460	32,461	37,870	37,871	& over
3	0	27,320	27,321	34,150	34,151	40,980	40,981	47,810	47,811	& over
4	0	33,000	33,001	41,250	41,251	49,500	49,501	57,750	57,751	& over
5	0	38,680	38,681	48,350	48,351	58,020	58,021	67,690	67,691	& over
6	0	44,360	44,361	55,450	55,451	66,540	66,541	77,630	77,631	& over
7	0	50,040	50,041	62,550	62,551	75,060	75,061	87,570	87,571	& over
8	0	55,720	55,721	69,650	69,651	83,580	83,581	97,510	97,511	& over
9	0	61,400	61,401	76,750	76,751	92,100	92,101	117,390	117,391	& over
10	0	67,080	67,081	83,850	83,851	100,620	100,621	127,330	127,331	& over
11	0	72,760	72,761	90,950	90,951	109,140	109,141	137,270	137,271	& over
12	0	78,440	78,441	98,050	98,051	117,660	117,661	147,210	147,211	& 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. This form must be updated every calendar year. If section 3 is NOT completed, update the financial record accordingly.

Nominal Fee:

- $20 for medical services
- $20 for vision services
- $20 for preventative and diagnostic dental services
- $30 for restorative and emergency dental services

The nominal fee is not based on the actual cost of services

Date_____

Health History - 2026-2027

Student's Name	Date of Birth	Grade
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 / medications / food - (please list at the bottom of the page)	Y N	Y N
Life Threatening Allergy to:_____ EpiPen prescribed	Y N 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
List of all allergies:		

History for Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/Concussion? When	Y N 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 Wears Glasses	Y N Y N	Y N
Surgery? List all:_____	Y N	
List all medications taken:		

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 accidentally 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 extent 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 having 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