Welcome to the School-Based Health Center

Crossroad Health Center – Mt. Auburn at Taft Elementary

Enrollment Packet

Welcome to Crossroad Health Center – Mt. Auburn. The School-Based Health Center makes medical care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center.

PLEASE COMPLETE AND SIGN ALL PAGES.

Patient's Name:_____**DOB:**_____**Sex: M __or F____**

Patient's Social Security # (if known)_____**Insurance Provider:**_____**Ins. #:**_____

PRIMARY HEALTH CARE SERVICES:

___**YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (includes work, daycare, and sports physicals) appropriate immunizations, and treatment for illness or injury including over the counter medications unless emergency services are needed.

___**NO,** I do not wish for my child to receive **MEDICAL CARE** at Crossroad Health Center – Mt. Auburn

Please note that 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.

FLU VACCINE:

___**YES,** I consent for my child to receive the **FLU VACCINE** at Crossroad Health Center – Mt. Auburn

___**NO,** I do not wish for my child to receive the **FLU VACCINE**

COVID VACCINE:

___**YES,** I consent for my child to receive the **COVID VACCINE** at Crossroad Health Center – Mt. Auburn

___**NO,** I do not wish for my child to receive the **COVID VACCINE**

By signing this consent, I agree to the terms and conditions regarding the PAYMENT FOR SERVICES & SHARING OF HEALTH INFORMATION as explained in the accompanying 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 received the **Notice of Privacy Practices,** which is attached separately.

_____ _____

Parent/Guardian Signature **Date** **Parent/Guardian's Printed Name**

_____ _____

Patient's Signature (if 18 or older) **Date** **Patient's Printed Name**

(*Note: well child care includes vision and hearing screening, urine and blood tests as needed, immunizations as needed, and an external genital exam when appropriate)

(Please continue to the next page)

Crossroad Health Center –

Mt. Auburn

Student Information

In order to provide health services for your child we need the following information:

Child's Name	Date of Birth	Insurance Provider Name	Insurance Number
		□ CareSource □ United □ Molina □ Paramount □ Buckeye □ Other_____	ID# MMIS#

Parent/Guardian Name:_____Parent/Guardian's Date of Birth: _____

Relationship to Child:_____Parent/Guardian's Social Security No.: _____

Address: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Emergency Contact Person:_____Phone Number: _____

Regular Medical Doctor or Clinic: _____

Address_____Phone #: _____

Date of last complete yearly physical examination (head to toe): _____

Regular Dentist/Clinic:_____Phone #: _____

Date of last routine dental check-up: _____

Do you want a copy of the physical exam to go to your clinic or doctor? Yes_____No_____

Preferred Pharmacy:_____Pharmacy Phone #: _____

Parent/Guardian Signature_____ Date of Signature_____

(Please continue to the next page)

HEALTH HISTORY FORM

Please complete, sign and return to the school office as soon as possible.

CHILD NAME_____

1. Is your child allergic to any medications?

No_____ Yes_____If yes, please list: _____

2. Any severe food allergies? Please list _____

Any other allergies? Please list _____

3. Does your child or any family member have or had any of these problems? (Please Check)

	Child | Family		Child | Family		Child | Family
Asthma or wheezing	____ ____	Fainting with exercise	____ ____	Migraines	____ ____
Allergies/hay fever	____ ____	Frequent Headaches	____ ____	Seizure Disorder	____ ____
ADHD / ADD	____ ____	Frequent Sore Throats	____ ____	Sickle Cell Disease	____ ____
Anemia / blood problems	____ ____	Frequent Stomach Aches	____ ____	Sinus Trouble	____ ____
Anaphylactic reaction	____ ____	High Cholesterol	____ ____	Sleep Problems	____ ____
Abnormal spinal curvature	____ ____	Heart Murmur	____ ____	Snoring	____ ____
Alcohol / Drug Abuse	____ ____	Hearing Loss	____ ____	Speech Problems	____ ____
Acne	____ ____	Heart Disease	____ ____	Stomach Ulcers	____ ____
Behavior problems	____ ____	High Blood Pressure	____ ____	Suicide	____ ____
Boys: testicle not in sac	____ ____	HIV / Aids	____ ____	Stroke	____ ____
BM in pants	____ ____	Hives	_____	Toothache/Dental problems	____ ____
Broken bones	____ ____	Hyperactivity	____ ____	Tuberculosis	____ ____
Cancer – type	____ ____	Joint problems	____ ____	Underweight	____ ____
Chicken pox	____ ____	Kidney Disease	____ ____	Urinary Tract Infections	____ ____
Diarrhea/ constipation	____ ____	Lead Poisoning	____ ____	Vaginal Discharge	____ ____
Chronic ear infections	____ ____	Learning Problems	____ ____	Wetting during day or night	____ ____
Concussion	____ ____	Leukemia	____ ____		
Depression	____ ____	Lumps in groin/breast	____ ____	**Please explain any check marks**:	
Diabetes	____ ____	Muscle Problems	____ ____	_____	
Dizziness / Light headed	____ ____	Nervous twitches / Tics	____ ____	_____	
Eczema / skin infections	____ ____	Nose Bleed	____ ____	_____	
Eye problems	____ ____	Nightmares	____ ____	_____	

4. Did your child have any of these problems?

Prematurity or birth weight under 5 lbs._____ Difficult delivery_____

Poor growth/slow development in infancy_____Drugs or alcohol used during pregnancy _____

Other problems in infancy including development_____

5. Does your child CURRENTLY take any medications?

No_____Yes_____If Yes, name of medication(s):_____

6. Has your child taken any medication(s) in the past? No_____Yes_____

List:_____

7. Has your child had any operations, serious injuries or hospitalizations?

No_____Yes_____Explain:_____

8. Has your child ever been pregnant?

No_____Yes_____If Yes, how many living children has your child given birth to?:_____

9. Has your child been a victim of abuse? No_____Yes_____

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, institutionalized children or adults, illegal drug users, or migrant farm workers? YES_____NO_____

Please circle yes or no below, and explain any yes answers on the line provided regarding your child:

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

School Concerns

Please circle yes or no below, and 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)?	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_____

Signature of Parent/Guardian_____Date_____

Thank you for your time used in completing your child health history and consent form.

THE FOLLOWING PAGES ARE FOR YOU TO REVIEW AND KEEP FOR YOUR RECORDS

Program Description School-Based Health Center
Crossroad Health Center – Mt. Auburn

Welcome to Crossroad Health Center – Mt. Auburn. The School-Based Health Center makes medical care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, eye exams, and all associated health care concerns .Any necessary prescriptions will be provided.
- After your child's visit with the provider, attempts will be made to contact you as necessary. .
- **The School-Based Health Center does not take the place of your regular doctor and joining the program does not mean you are changing your child's doctor.** You will be encouraged to have any needed follow-up care with that physician and a summary of your child's visit at Crossroad will be sent to that office. However, if you do not have a regular doctor, we welcome that relationship here and can become your child's doctor. If your child is already a patient of Crossroad Health Center, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Crossroad Health Center sliding fee scale. This information will be kept strictly confidential.
- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at the CRHC. If your insurance does not cover CRHC, you will be responsible for the bill at the appropriate discounted fee based on your household income.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-381-2247.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The School-Based Health Center and/or Crossroad Health Center (CRHC) will share medical information with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Crossroad Health Center – Mt. Auburn may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Crossroad Health Center's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Crossroad Health Center – Mt. Auburn reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Crossroad Health Center at 5 East Liberty Street, Cincinnati, OH 45202.

With my consent, Crossroad Health Center – Mt. Auburn may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Crossroad Health Center – Mt. Auburn may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Crossroad Health Center – Mt. Auburn restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Crossroad Health Center – Mt. Auburn uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the Crossroad Health Center – Mt. Auburn may decline to provide treatment to me.

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*Please note that the Crossroad Health Center – Mt. Auburn is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the Crossroad Health Center – Mt. Auburn or not.

This consent will remain in effect until your child is no longer enrolled in Cincinnati Public Schools. You **may revoke** this consent for treatment at any time by requesting the Crossroad Health Center – Mt. Auburn, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Crossroad Health Center at 513-381-2247 or contact your school nurse.