Student Information, Enrollment and Consent Form
WinMed Fast Track School-Linked and School-Based Health Center Program
Winton Hills Medical and Health Center, Inc. dba WinMed Health (WinMed)
PLEASE FILL OUT A SEPARATE FORM FOR EACH CHILD ENROLLED IN THE SCHOOL! PLEASE FILL OUT COMPLETELY!

Name of Child's School:				
Child's Name:				Date of Birth:
Social Security Number:		Child's Sex at birth:	Race:	Ethnicity:
Language:	Homeless: Yes No	Veteran: Yes No	Public Housing: Yes No	Agricultural Worker: Yes No
Parent/Guardian Name:				Date of Birth:
Parent/Guardian Social Security Number:			Parent/Guardian Relationship to child:	
Child's Address:				Zip Code:
Home Phone:	Cell Phone:	Work Phone:	Child's Cell#:	
Email Address:				
Emergency Contact Person:			Phone #:	

Check Gender Identity for ages 12 years and older	( ) Male	( ) Female	( )Transgender Male - Female	( ) Other
			( ) Transgender Female-Male	( ) Decline to answer
Check Sexual Orientation for ages 12 years and older	( ) Straight or Heterosexual	( ) Lesbian, Gay, Homosexual	( ) Bisexual	( ) Something else
			( ) Don't Know	( ) Decline to answer

Medical Information:

Childs Regular Medical Doctor:		Phone #:
Medical Doctor Address:		
Date of last physical and where:		
Date of last immunization(s) and where:	Do you have a current shot record?	If yes, please attach a copy.
Child's Regular Dentist:		Phone #:
Dentist Address:		
Date of last dentist visit and where:		

Consent to Fast Track School-Linked and School-Based Health Center Program:

Welcome to the Fast Track School-Based Medical Outreach Program! Please check **YES** in each section to agree to consent for services for your child. If you do not agree for a specific section, please check **NO.**

Has your child been enrolled at any other School-Linked/Based Medical Center? If yes, what school?_____

Have your child received medical or dental services with WinMed Health Services? ☐ **Yes** ☐ **No**

MEDICAL OUTREACH HEALTH CARE SERVICES:

☐ **Yes,** I consent for my child to receive **MEDICAL SERVICES** as explained in the accompanying Fast Track Program Description form/brochure.

☐ **No,** I do not consent for my child to receive **MEDICAL SERVICES.**

DENTAL HEALTH CARE SERVICES:

☐ **Yes,** I consent for my child to receive **DENTAL CARE SERVICES** as explained in the accompanying Fast Track Program Description form/brochure.

Note: Dental services are not offered at all the schools.

☐ **No,** I do not consent for my child to receive **DENTAL CARE SERVICES**.

Consent to Fast Track School-Linked and School-Based Health Center Program:

TRANSPORTATION SERVICES:

☐ **Yes,** I consent for my child to be **TRANSPORTED/WALK** to and from WinMed or WinMed nearby site by a representative of the CAA or WinMed, if I cannot be contacted and/or cannot accompany my child.

☐ **No,** I do not consent for my child to be **TRANSPORTED.**

MEDICATION SERVICES: If your child needs medication as part of his/her treatment, how do you want to get them?

Pharmacy (Required): _____ Phone #: _____

☐ Have the medication called/electronically sent to your pharmacy. ☐ Want printed prescription(s) for you to fill yourself.

☐ Want to pick the medication up from school.

BY SIGNING THIS CONSENT:

- I agree to the terms and conditions regarding **PAYMENT FOR SERVICES** and **SHARING OF HEALTH INFORMATION** as explained in the available Fast Track Program Description form/brochure.
- I have also received and agree with the **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORAMATION** as explained in the available Fast Track Program Description form/brochure.
- I have received the available **NOTICE OF PRIVACY PRACTICES,** and can request a copy if needed.
- I have agreed that the consent can be used for other school-based health centers as long as the student attends Cincinnati Public and St. Bernard-Elmwood Place School Districts that services are rendered by WinMed Health Services. I will also provide updated information pertaining to the student.

WHAT TYPE OF INSURANCE DOES YOUR CHILD HAVE? Please check all that apply

☐ Buckeye ☐ CareSource ☐ Medicaid ☐ Molina ☐ AmeriHealth Caritas of OH ☐ UnitedHealthcare ☐ BCBS Insurance #: _____

☐ Type of Income: Please circle - Employed, ADC, SSI, DA, Child Support Amount:$ _____ (weekly, Bi-weekly, or month)

Primary Card Holder's Information	Private Medical Insurance	Private Dental Insurance
Name of Insurance		
Social Security Number		
Date of Birth		
Identification Number		
Group Number		
Insurance Claims Address (on back of card)		
Insurance Claims City, State, & Zip		

☐ **No Insurance at this time: Please attach a copy of proof of income for income verification for child without insurance to use the sliding fee scale. The number of dependents under the age of 18, including spouse and self._____ Would you like to receive insurance information?** ☐ Yes ☐ No

_____ _____

Parent/Guardian Signature (required) Date of Signature (required)

WinMed Health Consent & Privacy Practices

Winton Hills Medical Center	WinMed at City West	WinMed at CAA
5275 Winneste Ave	1019 Linn St	1740 Langdon Farm Rd
Cincinnati, OH 45232	Cincinnati, OH 45203	Cincinnati, OH 45237
P513-242-1033/F513-242-2855	P513-233-7100/F513-407-3451	P513-631-7100/F513-417-8335

School-Based Health Centers

Bond Hill Academy • Winton Hills Academy • Woodward Career Technical High School

Elmwood Place Elementary • St. Bernard Elementary • St. Bernard-Elmwood Place Jr./Sr. High

By signing this form, I am consenting to WinMed Health's uses and disclosures of my Protected Health Information (PHI) to carry out Treatment, Payment, & Operations (TPO).

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, WinMed Health may decline to provide treatment to me.

Please check how you prefer to receive communications below

- Consent to Text or Call for Appointment Reminders & Communications

I consent for WinMed Health to communicate with me regarding appointments and health outreach by:

- □ Call with appointment communications
- □ Text with appointment communications
- □ E-mail with appointment communications
- □ All communications

- Consent to Obtain Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include medications purchased without using your health insurance. Also over-the-counter medications, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form, you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues, such as depression.

By signing below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices if requested.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

Dear Parent or Guardian: Please complete this SBHC Application and return them to the school nurse. Thank you.

HEALTH HISTORY FORM

This form is required by Ohio State law. Please complete, sign and return to the school health office as soon as possible.

CHILD'S NAME_____ **DOB**_____

SCHOOL _____ **GRADE**_____ **ROOM**_____

1. Is your child allergic to any medications? No_____ Yes_____
List:_____

2. Any food allergies? (Please list) _____

Any other allergies? (Latex, Environmental, Insect Bites/ Stings) (Please list)

_____

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

	Child	Family
Abnormal spinal curvature	____	____
Allergies/hay fever	____	____
Asthma or wheezing	____	____
Boys: Testicle not in sac	____	____
Cancer - type _____	____	____
Chronic ear infections	____	____
Diabetes	____	____
Elevated lead levels	____	____
Fainting with exercise	____	____
Frequent headaches	____	____
Heart disease –	____	____
High Cholesterol	____	____
Hyperactivity	____	____
Learning problems	____	____
Migraines	____	____
Nightmares	____	____
Seizure disorder/epilepsy	____	____
Sleep problems	____	____

	Child	Family
Acne	____	____
Anemia Or other blood problem	____	____
Attention deficit disorder	____	____
BM in Pants	____	____
Chicken pox	____	____
Concussion	____	____
Dizziness/ Light Headed	____	____
Emotional/ Psychological problems	____	____
Frequent sore throats	____	____
Heart murmur	____	____
Hepatitis	____	____
HIV/Aids	____	____
Kidney disease	____	____
Leukemia	____	____
Muscle/joint problems	____	____
Nose Bleed	____	____
Sickle cell disease	____	____
Snoring	____	____

	Child	Family
Alcohol / Drug Abus	____	____
Anaphylactic reaction	____	____
Behavior problems	____	____
Broken Bones	____	____
Chronic diarrhea or constipation	____	____
Depression	____	____
Eczema/chronic skin infections	____	____
Eye problems/ poor vision	____	____
Frequent stomach aches	____	____
Hearing loss	____	____
High/low blood pressure	____	____
Hives	____	____
Lead Poisoning	____	____
Lumps in groin/ breast	____	____
Nervous twitches or tics	____	____
Overweight	____	____
Sinus trouble	____	____
Speech problems	____	____

HEALTH HISTORY FORM, continued

Stomach ulcers	_____ _____	Stool soiling	____ _____	Stroke	_____ _____
Suicide	_____ _____	Toothaches/dental	____ _____	Tuberculosis	_____ _____
Underweight Problems	_____ _____	Urinary tract infections	____ _____	Vaginal Discharge	_____ _____
Wetting Day/ Night	_____ _____	Abuse/ Domestic Violence	____ _____	**Other:**	_____

Please explain any "Yes" answers:

_____

_____

_____

_____

_____

Please list any other health problems or illnesses:_____

Does your child see any specialist for items you checked above?
List:_____

4. Did your child have any of these problems?

Prematurity or birth weight under 5 lbs._____ Difficult delivery/ birth_____

Poor growth/slow development in infancy _____ Exposure to Drugs or alcohol during pregnancy _____

Other problems in infancy_____

5a. Does your child CURRENTLY take any medications? No _____ Yes_____
If Yes, name of medication(s):_____

_____

5b. Has your child taken any medication(s) in the past? No_____ Yes_____ List:_____

_____

_____

6a. Has your child had any operations, serious injuries or hospitalizations? No____ Yes_____
Explain:_____

_____

6b. Specifically, has your child had any heart surgery? No_____Yes_____
Explain:_____

7. Has your child ever been pregnant?
No_____ Yes_____ If yes, how many living children has your child given birth to?_____

8. Has your child been a victim of abuse? No_____ Yes_____ If yes, when _____

9. Does your child have any dental problems and/or toothaches? Yes_____ No_____

10. Is your child on any special diet or have special diet needs? Yes_____ No_____
Explain:

_____

11. Tuberculosis (TB) Risk Assessment
Is your child in contact with any of the following persons: immigrant 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? No _____ Yes_____ If yes, please circle the type of contact your child has had and state when _____.

HEALTH HISTORY FORM, continued

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? No Yes If yes, when: _____
Is an immigrant? No Yes If yes, from where: _____
Has traveled to another country? No Yes If yes, when and where: _____
Has ever been in jail or 20/20? No Yes If yes, when and where _____

12. School Concerns

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

Does your child have any learning problems? No Yes
_____

Is your child in a special class (Special Ed)? No Yes
_____

Has your child repeated a grade? No Yes
_____

Does your child get into trouble often at school? No Yes
_____

What are your child's grades? (A, B, C, D, F, S, U/s) _____ Is this a change? Yes _____ No _____

13. Do you have any concerns you want the health care provider to address now?

_____
_____
_____

_____ _____
Parent/Guardian Signature (required) *Date of Signature (required)*

Please return the completed SBHC Application pages 1-3 to your child's school to finish the enrollment process. You may keep the Private Policy for your records.

Thank you for your cooperation!

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"For Parents of Adolescents" – Please complete the additional section below:

For Adolescent Medical History: Has your adolescent child ever had?

STDs No	Yes	Sexual Activity No	Yes	Drug Use No	Yes
Exposure to Violence No	Yes	**Interest in Family Prevention Advice** No	Yes	Alcohol Use No	Yes
Do you feel safe? No	Yes	Do you feel sad all the time? No	Yes	Smoking or Tobacco Use No	Yes

Authorization for Administration of Over-the Counter Medications at School

This form expires at the end of the current school year

Student's Name _____ Date of Birth _____ School Year _____

Street Address _____ Apt. No. _____ City _____ State _____ Zip _____

School _____ Grade _____ Homeroom _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. *Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist) *Complete dosage and frequency above.

Provider's Signature: _____ Date: _____

Provider's Name: _____ Emergency Phone _____

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent or Guardian Date

_____

Please Print Name of Parent or Guardian

How can we reach you during school hours?

Work Phone _____ Cell Phone _____ Home Phone _____ Other _____

Woodward Career Technical High School
Over – The – Counter Medications Administration Log

Please complete the form as indicated. Please put your initials under the medication given to the student.

Student Name:_____ D.O.B._____ School Year:

Chief Complaint	Date of Service	Time of Service	Acetaminophen (Tylenol)	Ibuprofen	Anti-Itch Cream or Lotion	Cough Drops	Tums (Antacid)	Comments