Welcome to the School-Based Health Center
Cincinnati Health Department
Enrollment Packet

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

__ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school based health center (SBHC)
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.

DENTAL HEALTH CARE SERVICES:

__ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Clinic or school-based/mobile clinic 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. (Please see transportation section.)

__ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

EYE CLINIC SERVICES:

__ **YES,** I consent for my child to receive **EYE CLINIC SERVICES** at the OneSight Vision Center at Oyler School, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. (Please see transportation section.)

__ **NO,** I do not wish for my child to receive **EYE CLINIC SERVICES** at the OneSight School-Based Eye Center

TRANSPORTATION:

__ **YES,** I consent for my child to be **TRANSPORTED/ACCOMPANIED** to and from medical, dental or 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 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 be transported to or from school for these purposes.

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**

(Please continue to the next page)

School-Based Health Center

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.

city of CINCINNATI HEALTH DEPARTMENT

We know **health** matters

Consent for Nitrous Oxide Sedation

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

THE FOLLOWING PAGES

ARE FOR YOU TO REVIEW

AND KEEP FOR YOUR

RECORDS

Program Description
School-Based Health Center
Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision 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. If your child/adolescent develops a dental problem at school, a dentist can see your child at the Cincinnati Health Department (CHD) Price Hill Health Center (PHHC) or on the CincySmiles Dental Road Crew.

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, dental care, eye exams, and all associated health care concerns .Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, 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 CHD 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 and CHD clinics, 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.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

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 Cincinnati Health Department 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 CHD. If your insurance does not cover CHD, 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 513-357-2809. You can also contact the Hamilton County Job and Family Services Department at 946-1000.

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 PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse 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, School-Based Health Center or the CHD may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cincinnati Health Department'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. Cincinnati Health Department reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Price Hill Health Center at 2136 W. Eighth Street, Cincinnati, OH 45204.

With my consent, School-Based Health Center 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, School-Based Health Center or CHD 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 School-Based Health Center or CHD 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 School-Based Health Center's 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 School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center 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 School-Based Health Center, 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 the School Health Program 357-2809 or contact your school nurse.