

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

PLEASE COMPLETE AND SIGN ALL PAGES.

Patient's Name: _____ DOB: _____ Gender: M ___ F ___ Transgender _____

Pt's Social Security # (if known) _____ Medical card/Insurance: _____ 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, fluoride varnish 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). My child may 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 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. My child may 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 receive **DENTAL SERVICES**

EYE CENTER SERVICES:

YES, I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oylar School, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may 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 receive **VISION SERVICES**

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

Child's Name	Date of Birth	Medical Card or Insurance Name	Medical Card or Insurance Number
		CareSource United Molina Paramount Buckeye Other	ID# MMIS#

**School-Based Health Center
Student Information**

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

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

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

Address: _____ Zipcode: _____

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)

Student Name: _____

Please list any **CURRENT** health problems or conditions your student has (may be same as above): _____

Please list any allergies (include **food, medications**, environmental, seasonal, etc.): _____

Does your student see a specialist? If yes, please list condition, doctor's name, and phone number: _____

Please list any medications (prescribed or over-the-counter) your student takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): _____

SPECIAL NOTE: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you must complete a CPS Administration of Medication form. Revised 4/2016

Has your student had any operations, serious injuries or overnight hospital stays? No ___ Yes ___; please explain:

Has your student ever been pregnant? No ___ Yes ___; please explain:

Has your student had any operations, serious injuries or overnight hospital stays? No ___ Yes ___; please explain:

Has your student ever been a victim of abuse? No ___ Yes ___; please explain:

Has anything bad, scary or sad happened to your family? No ___ Yes ___; please explain:

School Concerns

Is your student in a special education class? No ___ Yes ___; please explain: _____

Has your student repeated a grade? No ___ Yes ___; details: _____

Does your student get into trouble at school? No ___ Yes ___; details: _____

What are your student's grades on the report card? _____

Any changes recently in grades? No ___ Yes ___

Signature of Parent/Guardian _____ Date _____

How can we reach you during school hours? Cell: _____ Work _____ other _____

Consent for Nitrous Oxide Sedation

Student 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

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.

- 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 513-357-2787. 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 you 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 its 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.

*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.