Wirt County Schools Wellness Center
#3 Schoolview Street P.O. Box 400
Elizabeth, WV 26143
Phone: 304-275-3117 Fax: 304 275-7255

STUDENT INFORMATION *

Student Name: _____ Student SS #: _____
Address- City: _____ Email: _____
State/Zip: _____ _____ Pharmacy: _____
Phone/Cell:_____ Grade: _____ Birth date: _____
Mother's Maiden Name:_____
Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:* _____

PARENT / GUARDIAN INFORMATION

Father: _____ Phone (H)_____
(W)_____ (C) _____Email: _____
Mother: _____ Phone (H)_____
(W)_____ (C) _____ Email: _____
Guardian: _____ Phone (H)_____
(W)_____ (C) _____ Email: _____

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact, If I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Name: _____ Relationship: _____ May we leave a message? __ Y __N

Phone: _____ _____ _____
Home Work Cell

Health Information *(Additional health, family & developmental history may be collected by your site)*

1. Doctor's name / phone number: _____
2. Name of Dentist: _____
3. If we need to call in a prescription, which pharmacy would you like us to call? _____
4. Immunizations:
   - ☐ I give my permission for you to obtain my child's immunization record
     Signature: _____Date:_____

INCOME INFORMATION – Please complete all that apply. **Please Circle the Following:**

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9

What is your estimated household monthly net income?

$100–500 $501-$1000 $100 –$1500 $1501-$2000 $2001-$2500 $2501-$3000

$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

My Child qualifies for free or reduced lunch? _____ Yes _____ No

Sliding Scale Fee information

Even if you have health insurance, this program may help you with the cost of health care at our facility. This program is offered through Coplin Memorial Community Health Center and may pay a portion of the costs for office visits at the Wirt County Schools Wellness Center. Families with insurance may qualify for deductible and co-pay discounts. Documentation required include a Wirt County Schools Wellness Center enrollment and consent form indicating how many people live in the household with the total family income and a copy of the two most recent check stubs for everyone in the household.

☐ **No health insurance / Request application for sliding fee / CHIP / Medicaid**

IF NO INSURANCE SKIP TO CONSENT PAGE

INSURANCE INFORMATION – Please complete all that apply

Responsible Party_____ Relationship_____

Child's Insurance Information – *Please check all that apply and send a copy of your insurance card(s)*

☐ **Primary Health Insurance:**
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Address (if different from child):
_____
_____
Place of Employment _____
Name of Insurance Company _____
Insurance Address
_____
_____
Insurance Phone / Fax Number _____
Group & ID Number _____

☐ **Secondary Health Insurance:**
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Name of Insurance Company _____
Insurance Address
_____
_____
Insurance Phone / Fax Number _____
Group & ID Number _____

☐ **Medicaid: Unisys Unicare Carelink Health Plan (please circle one)**
Medicaid ID#: _____ Member ID# _____
PCP/HMO Provider: _____ Provider Phone Number: _____

☐ **CHIP:** Name on Card: _____ Birth date of card holder: _____
ID or PIN # on card: _____ Group #: _____

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at Wirt County Schools Wellness Center SBHC. I understand that this consent form will be good until my child leaves/ graduates school or until I provide the Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving the SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided.

When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Student Name	Date of Birth	Signature of Parent / Legal Guardian	Date

Signature of Witness (this can be anyone)	Date

HIPAA OF 1996 ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. Please note there is an attached copy of HIPAA to this consent form, for the parent/guardian of the student receiving medical, dental or mental health counseling services at Wirt County Schools Wellness Center. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services. I certify that I have received a copy of Wirt County Schools Wellness Center's Notice of Privacy Practices (HIPAA). The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Wirt County Schools Wellness Center's health care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

Signature of Patient or Personal Representative	Date

Printed Name of Patient or Personal Representative	Description of Personal Representative Authority

Witness Signature	Date

Medical & Nursing Students, Select One:

Please initial here if you agree to have a student present during your child's care:_____

Please initial here if you DO NOT want a student present during your child's care:_____

OTHER SERVICES WE OFFER

Sports Physicals

Sports Physicals are provided year round at the Wellness Center.

Well Child Exam

Insurance will pay for one Well Child Exam per year. If you would like your child to have this exam provided by the Wellness Center, **please call our office and schedule the appointment**. The exam is based on the age of the child. We check hearing, basic vision screening, scoliosis, and assess if vaccines are current as well as a physical exam. Referrals are made as needed based on the outcome of the exam. It is helpful if a parent accompanies the child during this visit as there are questions the child may not be able to answer (especially if child is below 5th grade school level).

☐ **Yes I would like my child to receive a Well Child visit**

Portable Dental Unit

The portable dental unit visits schools twice a year for dental exams, fluoride treatments, cleaning and sealants. Services utilized through the Portable Dental Unit will be billed to your insurance. You will NOT be responsible for any portion of the bill not paid by your insurance. If you do not have dental coverage, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of this form**. To enroll in the portable dental unit, please complete The Portable Dental Unit Enrollment Form.** Referral to outside dentists may be necessary for additional or more comprehensive dental work. These referrals are not part of the portable dental unit. The parent or guardian is responsible for making payment arrangements with the referring dentist.

☐ **Yes, I would like my child to receive Mobile Dental Services. My child does not have a dentist.**

PLEASE COMPLETE PORTABLE DENTAL ENROLLMENT FORM ON THE NEXT PAGE.

☐ **No, my child already has a dentist. NAME OF CURRENT DENTIST:**_____

☐ **No, my child does not have a dentist but I do not want my child to have these services.**

Date: _____

Wirt County Schools Wellness Center Portal Dental Unit Enrollment Form

#3 Schoolview Street

PO Box 400

Elizabeth, WV 26143

Phone #: (304) 275-3117 Emergency #: (304) 588-3410

Dentist: Dr. Michael Wilson

Dental Hygienist: Merinda Birkett, RDH

The portable dental unit will be visiting your child's school at least twice during the school year. The first visit will be during fall and again in the spring.

Please return form to the school as soon as possible, in order to schedule appointments timely manner. Please note if your child has an appointment and the forms are not signed and returned for each dental visit, the appointment will be cancelled. If your child is going to another dentist and does not need these services please notify the Wellness Center at (304) 275-3117 that your child does not need these services.

Services will be billed to your insurance. You will NOT be responsible for any portion of the bill not paid by your insurance. If you do not have coverage, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of the enrollment and consent form.

If your child already has a dentist or has seen a dentist in the last 12 months, then they do not qualify for this program. Your insurance will not cover the fees of your regular dentist and services provided by the portable dental unit.

Name of Child _____DOB:_____

Name of Current Dentist:_____

Last visit with a dentist_____

If your child does not have a regular dentist and you would like your child to participate in the portable dental program, Please complete enrollment and consent form for Wellness Center Services sent home with your child and the following information.

Does your child have Dental Insurance? Circle Yes or No Name of Company_____

Address:_____

Phone:_____ Effective Date:_____

Policy Number:_____ Group Number:_____

Subscribers name:_____ Birth date:_____ SS#_____

Subscribers Address:_____

_____

Employer:_____

Medicaid: Yes or No Copy of card required. _____ Carelink _____ Unisys _____Unicare

_____ Health Plan. Family Case Number:_____ Child's Number:_____

Primary Care Provider listed on the Card:_____

May we leave a message on your phone with the date and time of your child's appointment if you are not available to take the phone call with the appointment information? Yes No

I, the parent or guardian of_____ give consent for him/her to have x-rays, cleaning, Fluoride treatment, sealants, and exam provided by portable dental unit staff and confirm by my signature this does child does not already have a dentist.

Parent/Guardian Signature:_____
Date:_____

PHOTOGRAPH RELEASE

I hereby authorize Wirt County Schools Wellness Center to use photographs taken of my child at the Wellness Center or at events put on by the Wellness Center. These photographs could be displayed on Wirt County Schools Wellness Center social media page (Facebook) and/or for publications of the WV School Based Health Assembly.

I hereby release and hold harmless Wirt County Schools Wellness Center from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Wirt County Schools Wellness Center, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Student's Printed Name: _____

Parent/Guardian's Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

HEALTH HISTORY FORM

STUDENT NAME:_____ **BIRTHDATE:**_____

FAMILY DOCTOR:_____ **PHONE:**_____

DENTIST:_____ **PHONE:**_____

MEDICATIONS TAKEN DAILY OR AS NEEDED BASIS

Medication_____ Dose(mg)_____ Directions:_____

Medication_____ Dose(mg)_____ Directions:_____

Medication_____ Dose(mg)_____Directions:_____

Medication_____ Dose(mg)_____ Directions:_____

ALLERGIES

Medication:_____

Food:_____Other:_____

Does the child have an order for and carry any of the follow: Check all that apply:

_____ Epi Pen _____ Insulin _____ Glucagon

MEDICAL HISTORY

List Chronic or Intermittent Disease or Health Problem

(example) Diabetes, Asthma, High Blood Pressure, Sinus Infections

_____

_____

SURGERY

List the type and date of the operation. (example – tonsils – Sept 2005)

_____

_____

SERIOUS INJURY OR ACCIDENTS

List type of accident and resulting injury and the date.

(example) Football accident, broken right lower leg, Oct. 2008

_____

_____

SOCIAL HISTORY

Tobacco Use: Yes: _____ Number of Packs per day NO

Alcohol Use: Yes:_____ Number of drinks per day. NO

Caffeine Use Yes: _____ NO

If you answered, Yes to caffeine use: check all sources that apply.

Sweet Soda Pop____ Number per day_____ Diet Soda Pop____ Number per day_____ Tea__ Number per day___

Coffee_____ Number per day___ Chocolate____ Number per day ____

Street Drug Use: Yes Name of Drug(s)_____ NO

FAMILY MEDICAL HISTORY: List disease by the appropriate family member.

Mother:_____

Father:_____

Brother:_____

Sister:_____

Mom's Mother_____

Mom's Father_____

Dad's Mother_____

Dad's Father_____

The information I have given is correct to the best of my knowledge. I understand that my medical information will remain confidential and it is my responsibility to inform the Wellness Center Staff of any changes in medical care and status. _____ **Date**_____

Parent/Guardian Signature