



Fairfield School-Based Health Center Enrollment Packet



PLEASE COMPLETE AND SIGN ALL PAGES.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M \_\_\_ or F \_\_\_

Patient's Last 4 of Social Security # (if known) \_\_\_\_\_ Insurance Provider: \_\_\_\_\_ Ins. #: \_\_\_\_\_

PRIMARY 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)

DENTAL SERVICES:

\_\_\_ YES, I consent for my child to receive DENTAL SERVICES at a Primary Health Solutions 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. (Treatment plan will be approved with parents / guardians prior to starting.)

\_\_\_ NO, I do not wish for my child to receive DENTAL SERVICES

VISION SERVICES:

\_\_\_ YES, I consent for my child to receive VISION SERVICES at the OneSight Vision Center at Fairfield Schools, 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 VISION 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 Primary Health Solutions, its Board members, employees, and authorized agents and representatives and the Fairfield City 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)



**Fairfield School-Based  
Health Center  
Student Information**



Child's Name	Date of Birth	Insurance Provider Name	Insurance Number
		<input type="checkbox"/> CareSource <input type="checkbox"/> United <input type="checkbox"/> Molina <input type="checkbox"/> Paramount <input type="checkbox"/> Buckeye <input type="checkbox"/> Other_____	<b>ID#</b> <b>MMIS#</b>

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 Last 4 digits of 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	_____	_____	_____	Seizure Disorder	_____	_____	_____
Allergies/hay fever	_____	_____	_____	Frequent Headaches	_____	_____	_____	Sinus Trouble	_____	_____	_____
ADHD / ADD	_____	_____	_____	Frequent Sore Throats	_____	_____	_____	Sleep Problems	_____	_____	_____
Anemia / blood problems	_____	_____	_____	Frequent Stomach Aches	_____	_____	_____	Snoring	_____	_____	_____
Anaphylactic reaction	_____	_____	_____	High Cholesterol	_____	_____	_____	Speech Problems	_____	_____	_____
Abnormal spinal curvature	_____	_____	_____	Heart Murmur	_____	_____	_____	Stomach Ulcers	_____	_____	_____
Alcohol / Drug Abuse	_____	_____	_____	Hearing Loss	_____	_____	_____	Suicide	_____	_____	_____
Acne	_____	_____	_____	Heart Disease	_____	_____	_____	Stroke	_____	_____	_____
Behavior problems	_____	_____	_____	High Blood Pressure	_____	_____	_____	Toothache/Dental problems	_____	_____	_____
Boys: testicle not in sac	_____	_____	_____	HIV / Aids	_____	_____	_____	Tuberculosis	_____	_____	_____
Bowel Movement in pants	_____	_____	_____	Hives	_____	_____	_____	Underweight	_____	_____	_____
Bleeding Disorders	_____	_____	_____	Hyperactivity	_____	_____	_____	Urinary Tract Infections	_____	_____	_____
Broken bones	_____	_____	_____	Joint problems	_____	_____	_____	Vaginal Discharge	_____	_____	_____
Cancer – type	_____	_____	_____	Kidney Disease	_____	_____	_____	Wetting during day or night	_____	_____	_____
Chicken pox	_____	_____	_____	Lead Poisoning	_____	_____	_____	<b>Additional behavioral, medical, dental, or vision concerns or known conditions:</b>			
Diarrhea/ constipation	_____	_____	_____	Learning Problems	_____	_____	_____				
Chronic ear infections	_____	_____	_____	Leukemia	_____	_____	_____				
Concussion	_____	_____	_____	Lumps in groin/breast	_____	_____	_____				
Depression	_____	_____	_____	Muscle Problems	_____	_____	_____	<b>Please explain any check marks:</b>			
Diabetes	_____	_____	_____	Nervous twitches / Tics	_____	_____	_____				
Dizziness / Light headed	_____	_____	_____	Nose Bleed	_____	_____	_____				
Eczema / skin infections	_____	_____	_____	Nightmares	_____	_____	_____				
Eye problems	_____	_____	_____	Migraines	_____	_____	_____				

**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 \_\_\_\_\_**

**10. Has your child been a victim of bullying? 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? 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.**

## 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 Primary Health Solutions 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 (“Novocain”). 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.

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Signature (Parent/Guardian)

Phone Number

Date

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

Welcome to Primary Health Solutions' Fairfield 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 without having to take time away from work and minimize the time that your child is out of the learning environment.

#### 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 primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with that PCP and a summary of your child's visit at the SBHC will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and can become your child's PCP. If your child is already a patient of any Primary Health Solutions locations, 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 (513) 454-1111.

#### 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.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol.
- 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 Primary Health Solutions 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 Primary Health Solutions. If your insurance does not cover Primary Health Solutions, 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) 454-1111. You can also contact the Butler County Job and Family Services Department at (513) 887-5600.

#### 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 PCP.
- Primary Health Solutions, the School-Based Health Center and/or the Fairfield City Schools' nurses 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.

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#### **Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, School-Based Health Center or Primary Health Solutions may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Primary Health Solutions' 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. Primary Health Solutions 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 Primary Health Solutions at 210 South Second Street, Floor 2, Hamilton, OH, 45011.

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 Primary Health Solutions 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 Primary Health Solutions 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 Fairfield 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 Primary Health Solutions at (513) 454-1111 or contact your school nurse.