FOREST HILLS MIDDLE SCHOOL

1210 NW Forest Hills Road
Wilson, NC 27893
252-399-7913

Dear Parent:

The Wilson County School Based Health Center advocates for the health of children and addresses a broad range of needs. Our purpose is to provide affordable, and accessible, physical, and preventive health services to adolescents.

The Wilson County School Based Health Center here at Forest Hills Middle School is located on the campus and is open Monday through Friday during School hours. The staff includes a full time Registered nurse, a nurse practitioner/physician assistant and additional support staff.

Students with health insurance or Medicaid coverage will be asked to provide information to allow for billing of nurse practitioner/physician assistant services. Students without insurance coverage will be billed on a sliding fee according to their income and number of supported members in the household. The Wilson County School Based Health Center **can bill most commercial insurances and Medicaid.** There will be **no charge** for registered nurse services. No sick student that has a signed consent form will be turned away for failure to pay or lack of insurance.

The goal for the Wilson County School Based Health Center is to help students succeed in school by promoting healthy lifestyles, and providing comprehensive health care to meet the needs of all students.

If you have any questions or concern, please contact Wilson County Health Department at 252-237-3141. We appreciate your interest and support of the Wilson County Based Health Center.

WILSON COUNTY SCHOOL BASED HEALTH CENTER NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU.

Each time you visit a hospital, physician or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool we can assess and continually work to improve the care we render and outcomes we achieve
- Understanding what is in your record and how your health information is used to help you to ensure its accuracy, better understand who, what, when, where, and why others may access your information so you can make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain an accounting of disclosures of your health information
- Request communication of your health information by alternative means or locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization (Wilson County School Based Health Center) is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Examples of Disclosures for Treatment, Payment and Health Operations

- We will use your health information with treatment
- We will use your health information for payment
- We will use your health information for regular health operation

Business Associates: There are some services provided ion our organization through contracts with business associates. When these services are contracted, we may disclose your health information to them so that they can provide the service we've asked them to do and bill you at your third party payer for services rendered. All standards of confidentially are rendered under Wilson County Health Department policy.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant t that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product/product defects, or post marketing surveillance information to enable product recall, repairs, or replacement.

Public Health: As required by law, we may disclose your health information or public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engages in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or in the public.

If you have any questions concerning these Privacy Practices you may contact the privacy Officer at (252) 237-3141.

_____

I have read and understand the Notice of Privacy Practices of the Wilson County School Based Health Center.

Signature_____ Date_____

WILSON COUNTY SCHOOL BASED HEALTH CENTER

School Year 2016-2017 (July 1, 2016-June 30, 2017)

NOTE: This Permission Form is valid for the 2016-2017 school year,

Please complete in black ink. *If Legal Guardian, you must provide copy of the Guardianship record with this form.

Student Name_____ School _____ Grade _____

Sex (Circle One): M F Date of Birth _____Social Security#_____ Ethnicity: Hispanic Non-Hispanic

Race (Circle One): **White Black American Indian Native Alaskan Asian Native Hawaiian Other Pacific Islander.**

Address_____City_____State_____ZIP_____

Name of Parent/Legal Guardian*_____Relationship to Student_____

Home Phone# _____Cell Phone# _____email address_____

Employer _____Work Phone#_____

Student's Physician_____ Office Phone#_____

Preferred Pharmacy_____ Phone # _____

Dentist_____ Phone#
_____

Emergency Treatment

An emergency exists if, in the judgement or the WCSBHC staff, treatment is immediately required to prevent deterioration or worsened patient condition. A minor may sign a request for treatment without the parent's consent if an emergency exists. Emergency care outside the defined scope of services of WCSBHC will be referred to the appropriate agencies. In emergency situations requiring acute care, WCSBHC personnel will contact the Emergency Medical System for transport of the student to the appropriate medical facility. In case of emergency, whom should we contact? Please list two emergency contacts:

Name **Phone Number**
Relationship to Student

1._____
_____

2._____
_____

As the parent or legal guardian of (**student name**) _____, I hereby give my permission for comprehensive health care and treatment and certify that the medical history given on the back of this page is accurate to the best of my knowledge. WCSBHC upholds the confidentiality of all patients, and will not release health information unless a written release of information form is completed and signed by the responsible party.

WE MUST HAVE YOUR SIGNATUR AND REQUESTED INSURANCE INFORMATION BEFORE YOUR CHILD CAN RECEIVE SERVICES

Parent/Guardian Name (please print)
_____

Parent/Guardian Signature
_____

Student Signature
_____

REIMBURSEMENT INFORMATION SERVICES CAN NOT BE PROVIDED WITHOUT THIS INFORMATION!

Please note that one of the ways you can support the WCSBHC is by providing your insurance or Medicaid information so that we can bill them for the medical services provided only by the Nurse Practitioner or Physician Assistant. No one will be denied care due to inability to pay. Please circle which pay source your child has: **Medicaid** **Insurance** **Self-pay**

Please provide the following information if applicable:

Medicaid Number_____

Insurance Company _____ Plan Name_____

Policy Holder Name _____

Group# _____ Policy #
_____

Self-Pay—number of dependents living in your household_____, **please provide copy of your last paycheck stub.**

The WCSBHC will work with individuals to set up monthly payments if requested.

***You may send your insurance card, Medicaid card, or verification of income by your child and we will be happy to make a copy for the child's medical file. We will immediately return the card to your child. Please include a copy of an updated immunization record if available.**

We would appreciate your returning this completed form and any other necessary information the WCSBHC. Medical information will be released to student's primary Care Physician to provide consistency of care and updated records. Thank you for your support.

07/16

MEDICAL HISTORY

(To be completed by the Parent or Legal Guardian)

Has your child had a physical in the last 12 months? Yes_____ No_____ **Please provide the date of last exam**:_____

Is your child allergic to any medicines? Yes____ No____ If yes, please list _____

Is your child allergic to any foods? Yes____ No____ If yes, please list_____

Is your child currently taking any medicine? Yes____ No____ If yes, please provide the following information on the medicines taken:

Name of Medicine	**Reason taken**	**How long taken**
_____	_____	_____
_____	_____	_____

Has your child ever been hospitalized overnight? Yes____ No____ If yes, give age at the time of hospitalization and describe the problem:

Age	**Problem**
_____	_____
_____	_____

Has your child ever had any serious injuries? Yes_____ No_____ If yes, please explain: _____

Please check ☑ whether your child ever had any of the following health problems: If yes, at what age did the problem start?

	Yes	No	Age		Yes	No	Age
ADHD/Learning disability	☐	☐	_____	Headaches/migraines	☐	☐	_____
Allergies/hay fever	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Asthma	☐	☐	_____	Pneumonia	☐	☐	_____
Bladder or kidney infections	☐	☐	_____	Rheumatic fever of heart disease	☐	☐	_____
Blood disorder/sickle cell anemia	☐	☐	_____	Scoliosis	☐	☐	_____
Cancer	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Chickenpox	☐	☐	_____	Severe acne	☐	☐	_____
Depression	☐	☐	_____	Stomach problems	☐	☐	_____
Diabetes	☐	☐	_____	Hyperthyroid/hypothyroid	☐	☐	_____

Eating disorder	☐	☐	_____	Other: _____	☐	☐	_____
Emotional Disorder	☐	☐	_____				
Hepatitis (liver disease)	☐	☐	_____				

Some health problems are passed from one generation to the next. Have you or any of your child's blood relatives (parents, brothers, sisters, grandparents, aunts, or uncles), living or deceased, had any of the following problems? If the answer is yes, please state the age of the person when the problem occurred and his or her relationship to your child.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	_____	_____
Arthritis	☐	☐	☐	_____	_____
Birth Defects	☐	☐	☐	_____	_____
Blood disorders/ sickle cell anemia	☐	☐	☐	_____	_____
Cancer	☐	☐	☐	_____	_____
Depression/Mental Health	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack/stroke before age 55	☐	☐	☐	_____	_____
Heart attack/stroke after age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seizures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Eastern Carolina Pediatrics, Wilson County Schools, Wilson County Health Department, and Wilson Medical Center or any primary physician or any other medical facility who has provided medical services to my child to release medical information to:

NAME: Wilson County School Based Health Center/Wilson County Health Department

ADDRESS: 1801 Glendale Drive SW

City: Wilson, NC 27893____ for any health information, medical records, immunization records concerning my child's health during the effective dates of the WCSBHC Parental Consent Form (form is renewed annually).

INSURANCE AND MEDICAL RELEASE FORM:

I hereby authorize Wilson County School Based Health Center to furnish information to insurance carriers and any physicians/hospital /counselor/health department concerning illness and treatment of my child.

I also authorize the release of any medical records or other information necessary to provide medical services and process insurance claims and hereby assign all payments of medical benefits to Wilson County School Based health Center (WCSBHC) and/ or contracted agencies/ individuals for mental heal and/ or nutritional services rendered. I understand that I am responsible for any amount not covered by insurance, and I agree to pay this amount to Wilson County School Based health Center or contracted agencies/individuals.

**_____ _____

PARENT SIGNATURE **DATE**

NUTRITION:

I give my permission for my child to receive nutritional counseling services at Wilson County School Based Health Center with a Registered Dietician affiliated with the WCSBHC.

Students may be referred for (1) nutritional guidance, (2) weight management, and (3) instruction on healthy eating habits.

**_____ _____

PARENT SIGNATURE **DATE**

7/16

School ID#

_____

PEDIATRIC SYMPTOM CHECKLIST (PSC) DOB

_____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these question. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	NEVER	SOMETIMES	OFTEN
1. Complains of aches and pains	1. _____	_____	_____
2. Spends more time alone	2. _____	_____	_____
3. Tires easily, has little energy	3. _____	_____	_____
4. Fidgety, unable to sit still	4. _____	_____	_____
5. Has trouble with teacher	5. _____	_____	_____
6. Less interested in school	6. _____	_____	_____
7. Acts as if driven by a motor	7. _____	_____	_____
8. Daydreams too much	8. _____	_____	_____
9. Distracted easily	9. _____	_____	_____
10. Is afraid of new situations	10. _____	_____	_____
11. Feels sad, unhappy	11. _____	_____	_____

12. Is irritable, angry _____ 12. _____ _____

13. Feels hopeless _____ 13. _____ _____

14. Has trouble concentrating _____ 14. _____ _____

15. Less interested in friends _____ 15. _____ _____

16. Fights with other children _____ 16. _____ _____

17. Absent from school _____ 17. _____ _____

18. School grades dropping _____ 18. _____ _____

19. Is down on him or herself _____ 19. _____ _____

20. Visits the doctor with doctor finding nothing wrong _____ 20. _____ _____

21. Has trouble sleeping _____ 21. _____ _____

22. Worries a lot _____ 22. _____ _____

23. Wants to be with you more than before _____ 23. _____ _____

24. Feels he or she is bad _____ 24. _____ _____

25. Takes unnecessary risks _____ 25. _____ _____

26. Gets hurt frequently _____ 26. _____ _____

27. Seems to be having less fun _____ 27. _____ _____

28. Acts younger than children his or her age _____ 28. _____ _____

29. Does not listen to rules _____ 29. _____ _____

30. Does not show feelings _____ 30. _____ _____

31. Does not understand other people's feelings _____ 31. _____ _____

32. Teases others _____ 32. _____ _____

33. Blames others for his or her troubles 33. _____ _____
_____

34. Takes things that do not belong to him or her 34. _____ _____
_____

35. Refuses to share 35. _____ _____
_____

Total Scores_____

Does your child have any emotional or behavioral problems for which she/he needs help? Yes____ No____

Are there any services that you would like your child to receive for these problems? Yes____ No____

If yes, what type of services?

_____

English PSC Gouverner Revision 01-06-03