Healthy Children Make Better Students

WELCOME BACK STUDENTS

Parent/Guardian, please complete all forms attached for each student in your household. This will give consent for them to receive health care services at their School-Based Health Center.

School-Based Health Centers can treat your child/children for the following services;

- **Acute Care (Sore throat, cough, earache, acne, etc.)**
- **Chronic Care, (High BP, Diabetes, etc.)**
- **Sport / CDL / Health Check Physicals**
- **Behavioral Health (Ritchie, Jefferson, South)**
- **Dental Services (Doddridge County)**
- **Vaccines**
- **Blood work**
- **Referrals**
- **Allergy Injections**
- **RRHC accepts all major insurances**

❖ Doddridge County

Doddridge County Elementary/ Middle School located directly **behind** Doddridge County Middle School

Doddridge County High School, located at the Doddridge County High School nurse office

❖ Pleasants County

St. Mary's High School-Based Campus located in the High School front entrance

❖ Ritchie County

Ritchie County School-Based Campus located in the Middle/High School at Ellenboro

❖ Wood County

Jefferson School-Based Campus – Located **behind** Jefferson Elementary School

Parkersburg South School–Based Campus -Located **behind** South High School in the parking lot

Please contact RRHC at 304-873-0060 if you have any questions.

RRHC is required to collect the following information due to receiving Federal Funding and to determine if your child may be eligible for financial assistance.

Student Full Name: ______________________________________ Student Date of Birth__________________

Student's Birth City______________________________ State_____ **(Circle One)** -Single Birth / Twin / Triplet

County of Residence_____________ Number in Household____ Annual Household Income $____________

Household members;
Name: ____ DOB ______________________
Name: ____ DOB ______________________
Name: ____ DOB _______________________
Name: ____ DOB _______________________
Name: ____ DOB _______________________
Name: ____ DOB _______________________

Student Race (Check one)

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Hispanic/Latino
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Refused to report/Unreported

Homeless Status

- ☐ Not homeless
- ☐ Homeless Shelter
- ☐ Transitional Housing (Temporary)
- ☐ Doubling Up (living with family, friends, etc.)
- ☐ Street (no housing)
- ☐ Other_______________________

Gender Identity:

- ☐ Female
- ☐ Male

Language

- ☐ English
- ☐ Spanish
- ☐ Other________________

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

RITCHIE REGIONAL HEALTH CENTER
2018-19 SCHOOL-BASED CONSENT FORM

Student's school: ________________________ Student Full Name: ____

____ ___________________________ ___________ ____________
Mailing Address City State Zip

_________________ _____________________________ _______________
Student Date of Birth Social Security Number Grade-Homeroom Child Lives with: Father / Mother / Both – Other

PARENTS/LEGAL GUARDIANS

Father's Name	Date of Birth	Social Security Number	Home Phone	Work Phone	Cell Phone
Mother's Name / Maiden Name	Date of Birth	Social Security Number	Home Phone	Work Phone	Cell Phone
Guardian's Name	Date of Birth	Social Security Number	Home Phone	Work Phone	Cell Phone

Please list any individual(s) as emergency contact, other than yourself, who have your permission to bring your child to be seen:
Name: Phone: Name: Phone:
Relationship to child: Relationship to child:

INSURANCE INFORMATION

Please check all that apply and send in a copy of insurance card(s) front and back.

☐ HEALTH (PRIMARY)

Name of Insurance Company	Policy/ID Number	Group Number
Billing Address		Phone Number
Insured's Name	Insured's Date of Birth	Insured's Social Security Number

☐ HEALTH (SECONDARY)

Name of Insurance Company	Policy/ID Number	Group Number
Billing Address		Phone Number
Insured's Name	Insured's Date of Birth	Insured's Social Security Number

☐ OTHER

☐ Medicaid ID Number:

☐ WV Children's Health Insurance Program (CHIP) Name on Card: Policy ID Number:

☐ No health insurance / Request application for sliding fee, CHIPS, Medicaid

***More Medical History Info and Parent Signature Also Needed on Other Side

Services Provided by RRHC School-Based Health Center's

Sport/Physical Exams	Treatment of	Behavior Health (Jefferson/Ritchie/South)	Prescriptions
Vaccines	Illness Lab Tests	Allergy Injections	Health Education

HEALTH INFORMATION

1) Primary Healthcare Provider(PCP) Name: ___________________________ ☐ Ritchie Regional Health Center is your child's PCP

2) Current Medications ____

3) Family Dentist: _________________________________ ☐ Ritchie Regional Health Center is your child's family dentist

Immunizations: Please attach a copy of your child's immunization record.

Please check if your child has ever had any of the following health problems:

Allergies: Bee sting ___________________________ Food___________________Medications _______________Other_______

Prescription for Epipen? Yes / No

☐	ADD/ADHD	☐	Diarrhea	☐	Mononucleosis
☐	Anemia	☐	Drug/Alcohol	☐	Mumps
☐	Asthma	☐	Ear Infections	☐	Pneumonia
☐	Bed Wetting	☐	Epilepsy/Seizures	☐	Rheumatic Fever
☐	Birth Defects	☐	Fainting	☐	Scoliosis
☐	Bladder Problems	☐	Hearing Problems	☐	Sinus Problems
☐	Cancer	☐	Heart Problems	☐	Speech Problems
☐	Cerebral Palsy	☐	Hepatitis	☐	Stomach Problems
☐	Chicken Pox	☐	Kidney Disease	☐	Thyroid Disease
☐	Constipation	☐	Lead Poisoning	☐	Tuberculosis
☐	Convulsions	☐	Measles	☐	Urinary Disease
☐	Diabetes	☐	Mental Illness/Depression	☐	Other_________________

Any other concerns you may have: ____

4) If a prescription is needed, which pharmacy would you like us to call____

5) If there are any services that you DO NOT want provided to your child, please list below:

In case of an emergency, every effort will be made by the health center staff to notify the parent/guardian. The health center will attempt to call parents/guardians when a child presents themselves to the health center to be seen by the provider. If we are unable to reach anyone, a note will be sent home with your student. I authorize that my child's photo can be taken for identity/security purposes and kept on file in the patient's chart.

I authorize a physician, nurse practitioner or designated health professional to provide necessary and/or advisable treatment for my child. Students may be asked to complete a questionnaire for screening and/or auditing purposes. I authorize release of written and verbal information pertinent to my son's/daughter's health care between the school nurse and the health center's staff only when necessary for his/her care. Notice of Privacy Practice is posted at the Health Center. I authorize the health center to release information regarding treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the health center. I am financially responsible for non-covered services but understand that services will not be denied due to inability to pay.

_______________________________________ _______________________________

Signature of Parent/Guardian Date

RITCHIE REGIONAL HEALTH CENTER
2018-19 SCHOOL-BASED DENTAL CONSENT FORM

Student's Full Name____________________________________ Parent/Guardian(s) Name: _________________________________

Mailing Address____ Phone: ______________________________

Grade ______ Homeroom Teacher ________________________ Sex: _____ Date of Birth________/________/__________

DENTAL INSURANCE INFORMATION
Please check all that apply and send in a copy of insurance card(s) front and back.

☐ Dental Insurance

____ ____________________________ ______________________
Name of Dental Insurance Company — Policy/ID Number — Group Number

____ ______________________
Insurance Billing Address — Insurance Phone Number

____ ______________________________ ______________________
Insured's Name — Insured's Date of Birth — Insured's Social Security Number

☐ OTHER

☐ Medicaid: ____________________________ Circle Medicaid HMO: Aetna Better Health / Health Plan / Unicare / WV Family Health
MA ID Number

☐ CHIP (WV Children's Health Insurance Program): ______________________________ ______________________
Name on card — Policy ID Number

☐ No dental insurance / Request application for sliding fee, CHIP, Medicaid

CONSENT FOR DENTAL TREATMENT

1) I authorize my child to receive dental care including examination, cleaning, x-rays, sealants (as needed) and fluoride treatment by Doddridge School-based Wellness Center dentist and dental hygienist during school hours.
2) I understand that my child will be scheduled during school class time to receive dental services by the School-based Wellness Center dental staff. I understand the dental staff will attempt to contact me as a reminder of the time of my child's appointment and the dental staff will treat my child if I choose to not be available during my child's appointment.
3) Once your child receives an exam, cleaning, x-ray, sealants and fluoride treatment, if additional dental treatment such as fillings, extractions, etc is needed then the Parent/Guardian will be contacted. NO ADDITIONAL TREATMENT (i.e. fillings, extractions, etc.) WILL BE COMPLETED WITHOUT THE PARENT'S ADDITIONAL CONSENT/PERMISSION.
4) I authorize the Doddridge County Wellness Center to release information regarding dental treatment to third party payer such as Medicaid or insurance for the purposes of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to the health center. I am financially responsible for non-covered services but understand that services will not be denied due to inability to pay.

☐ **NO Routine exam and cleaning** [Check this box if you DO NOT want your child to have routine dental exam and cleanings.] This would not exclude your child from future emergency treatment.

____ ________________________________
***PARENT/GUARDIAN SIGNATURE* — *Date*

***More Dental Health Info and Parent Signature Also Needed on Other Side

RITCHIE REGIONAL HEALTH CENTER
2018-19 SCHOOL-BASED Dental Health History

Please read carefully and complete **all** information on this page for your child to be seen and treated at the School-based Wellness Center by the dental staff.

Student's Full Name____ Date of birth_________________

Parent/Guardian(s) Name ____ Parent/Guardian Phone ________________

MEDICAL HISTORY

Please list the name and phone number of your child's physician:
Name____ Phone_____________________________
Date of last physical examination_____________________________________

1. Does the child have any health conditions? If so, please explain: ____
2. Is the child currently being treated for any illness(es)? If so, please explain: ___________________________________
3. Has the child ever been treated for any illnesses in the past? If so, when and please explain: _____________________
4. Does the child have any speech difficulties? ____Yes _____No
5. Does the child bleed excessively when cut? ____Yes _____No
6. Is the child physically, emotionally, or mentally impaired? If so, please explain: ________________________________
7. Does the child have any disease, condition or handicap not listed above? ___Yes ___ No
   If so, please explain____

DRUGS AND MEDICATIONS

1. Is the child taking ***any*** over the counter medications, vitamins, or prescriptions? ____Yes ____No
   If so, please list: Medication(s) & Condition(s) for: ____
2. Is the child **allergic** or ever had an allergic reaction to ***any*** prescription or over-the-counter (OTC) medications?
   If so, please explain: ____
3. Is the child allergic to latex? ____Yes ____No
4. Is the child allergic to sulfa drugs? ____Yes ____No
5. Does the child have **any other** allergies that we should be aware of such as seasonal, metals, food? ____Yes ____No
   If so, please explain: ____

DENTAL HISTORY

1. Is this the child's first visit to the dentist? ____Yes ____No
2. Does the child have a regular dentist? If yes, when and where____
3. Has the child ever had dental x-rays? ____Yes ____No. If yes, when and where _______________________________
4. Has the child ever had any restorative dental work such as fillings or extractions ____Yes ____No
   If yes, when and where and how was their experience ____
5. Does the child have any allergies to dental materials such as dental anesthetic, filling materials, etc.? ___Yes ___ No
   If yes, please tell reaction experienced____
6. Does the child presently have any dental complaints such as pain, bleeding gums, mouth sores, sensitive teeth? Yes / No
   If yes, please list____

I certify that the above information is true and correct to the best of my knowledge. I will not hold the dentist or any staff member responsible for action they take or do not take because of errors or omissions made in my completion of this form. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical and dental status.

***PARENT/GUARDIAN SIGNATURE** ____ Date ________________

Provider Initials: ________________ ***Notes:*** ____