School-Based Health Services

Hello Bracken County Parents:

We are happy to kick off the school year at our School-Based Health Center. The partnership between Bracken County Schools, Bracken County Health Department, Interact for Health, PrimaryPlus and the University of Kentucky College of Dentistry has helped bring this dream to reality—we had a successful first year in the new center located at 106 Powell St. and are ready for the 2023-24 school year with continued growth!

The new on-site center has allowed for increased accessibility with in-person visits for students, staff, and the entire community. The location offers family health (in-person two days a week), dental services (four days a week) and coming soon counseling services with Gary Zornes, LCSW. Note: Consent packets are for school-based **Primary Care & Dental services ONLY**. Counseling Services are referral based OR a parent/guardian can call to schedule for this service.

Again, telemedicine visits (which parents are welcome to participate in) will also remain an option for school health as needed.

Medical Services: School-based services are designed to be an added resource to parents and IS NOT designed to replace your child's pediatrician or routine medical provider. As a school-based health center, the goal is to provide a convenient, yet quality healthcare evaluation upon parental consent when your child has any minor sickness such as earache, throat infection, eye infection, skin irritation, cold, runny nose, etc. Bracken County Alumni, Cory Ramsey, PA-C, joined the PrimaryPlus medical family this year and offers care in the school-based center on Monday and Thursday (in-person) and is also available for care at PrimaryPlus-Bracken County. Again, our Brooksville School-Based Health office is open to students, but also open to the entire community…all ages are welcome to utilize this center.

Dental Services: The dental portion of this school-based health center is a collaboration between PrimaryPlus-Dental Center and the University of Kentucky College of Dentistry which will ensure all dental staffing needs are met featuring the care of Dr. Anna Joines, DMD and hygienist Jacqueline Stitt, RDH . University of Kentucky College of Dentistry has a strong foundation in school-based dentistry programs throughout the state. PrimaryPlus-Dental Center manages day-to-day operations of the facility. Our dental center is open four days a week. PrimaryPlus-Dental Center is also open for the entire community to utilize (all ages welcome). Dental services include dental exams, cleanings, x-ray and some restorative procedures.

Consent Information: Attached are the consent forms for 2023-2024 school-based services. Parents/guardians may select which services they would like their child to participate. **Consent packets will need to be completed and returned by September 8th. Students that return completed packets will have an opportunity to win one of three $100 gift cards provided by PrimaryPlus.** Note: If the student is already a patient of PrimaryPlus, they will **STILL** need to complete the forms because school-based services require added information and must be completed once a year—so last school years consent forms are no longer valid.

This partnership is geared towards ensuring happy, healthy kids and creating access to quality care for families of the region! You can find a list of frequently asked questions regarding school-based health and the PrimaryPlus *Notice of Privacy and HIPAA Practices* on the school website or at www.primaryplus.net.

Many Well Wishes for a Great School Year,

The PrimaryPlus Team

PrimaryPlus

Quality ✚ Advanced ✚ Affordable ✚ Healthcare

School Based Health Center Enrollment Form

SERVICE LIST CONSENT

Please read carefully, COMPLETE FORM, SIGN, and DATE. Students should return this form to their homeroom teachers. Please notify PrimaryPlus if there are any changes in health information or guardianship. PrimaryPlus collects new consents each school year. **If your child is already a patient of PrimaryPlus and you wish to participate in school-based health services, forms must be completed.**

Consent packets are for school-based **Primary Care & Dental services ONLY**. Counseling Services are referral based OR a parent/guardian can call to schedule for this service.

I give my consent for _____ _____ _____

Student's Full Name *Birth Date* *Social Security Number*

to receive the following services at PrimaryPlus School Based Health Center: **(PLEASE INITIAL)**

Initial	**Service Options Available for School-Based Health**
_____	**Nurse Practitioner /Telehealth Services** (NP/Telehealth services for acute illness, wellness exams, sports physicals, etc.) **Proceed to complete remainder of packet.**
_____	**Dental Services** (Dental Services include cleanings, radiographs, fluoride treatment, sealants, and exams) **Proceed to complete remainder of packet.**
_____	**No Services at this time** (You DO NOT need to complete the remainder of this form.)

Note: Consent is for school-based primary care and/or dental, all counseling services are by medical provider referral or parent requesting appointment.

I understand that PrimaryPlus shall provide a copy of its Notice of Privacy and HIPAA Practices upon my request, which is also available at www.primaryplus.net. I authorize PrimaryPlus to release any information required for payment of insurance claims and authorize my insurance , Medicare or Medicaid to be paid directly to the clinic. I understand that I am responsible for any co-payments and/or deductibles incurred from my insurance plan. If this cannot be done, I agree to make payments to the clinic. I authorize PrimaryPlus SBHC to release and receive medical information from the patient/my primary care providers and specialists. I give consent for this protected health information to be shared with school district staff who may need to provide care in an emergency situation. Furthermore, I give consent for PrimaryPlus SBHC staff, Board of Education staff, and the patient/my primary care provider, to communicate and share medical and psychological conditions on an as needed basis with the understanding that all the information will be treated in a confidential manner.

X_____ _____ _____

Parent or Guardian Signature Parent or Guardian Printed Name Date

Please note that if the parents of the above stated child have joint custody, signatures of both parents are required for consent to treat, please be sure to sign below

X_____ _____ _____

Parent or Guardian Signature Parent or Guardian Printed Name Date

Note: Patient/Student Signature is ONLY allowed if 18 or OLDER. If under 18, MUST be signed by parent/guardian.

PrimaryPlus shall provide a copy of its Notice of Privacy and HIPAA Practices upon my request, which is also available at www.primaryplus.net.

PrimaryPlus School-Based Health Registration Form

PATIENT INFORMATION Please Complete the following information about your child.			**Student's School:**
Child's Last Name:	First Name:		Middle:
Date of Birth: / /	Social Security Number: - -		Sex Assigned at Birth: Male☐ Female☐
First and Last Name of all Legal Parents/Guardians 1. 2.			
Street Address or PO Box:	City:	St:	Zip Code:
Guardian Home Phone: 1. 2.	Guardian Cell Phone: 1. 2.		Guardian Email Address: 1. 2.
Emergency Contact Name and Phone (Other than Guardian)			
Who is your child's Primary Care Physician? Phone: Fax:			
Would you like your child's visit notes to be sent to their Primary Care Physician? Y☐ N ☐ *PrimaryPlus is happy to share records of your child's visit with their pediatrician or regular primary care provider.			
Preferred Pharmacy? Phone:			
Primary Insurance Company Name:	ID Number:		Group Number:
Name of Policy Holder:	Policy Holder's Date of Birth:		Relationship to Patient:
☐Check this box if you do NOT have medical insurance. You may be contacted by our Community Health Worker.			

Past Medical History (Select All That Apply)			**Past Surgical History**
☐ No Past Medical History ☐ Asthma ☐ Anxiety ☐ Congenital Heart Defect ☐ Concussion or Head Trauma ☐ Depression ☐ Epilepsy/Seizures ☐ Hernia ☐ Sickle Cell Anemia ☐ MRSA Skin Infection	☐ Allergies ☐ Autism ☐ Cardiomyopathy ☐ Diabetes Type I ☐ Gastric Reflux ☐ High Blood Pressure ☐ Speech Disorder ☐ Meningitis ☐ Developmental Learning/ Disorder/Delay ☐ COVID-19 , Date of Diagnosis _____	☐ ADHD ☐ Anemia ☐ Cerebral Palsy ☐ Diabetes Type II ☐ Heart Murmur ☐ Hypothyroid ☐ Chicken Pox ☐ Smoking ☐ RSV ☐ Other, Please List:	☐ No Past Surgical History ☐ Tonsillectomy Date: ☐ Adenoidectomy Date: ☐ Appendectomy Date: ☐ Ear Tubes Date: ☐ Incision and Drainage Date: ☐ Other, Please List:

Family History (Please label below M for Mother, F for Father, S for Sibling and G for Grandparent)--List as many as needed			
☐ Anxiety_____ ☐ Depression _____ ☐ High Blood Pressure _____ ☐ High Blood Pressure _____ ☐ Pacemaker _____	☐ Asthma _____ ☐ Diabetes Type I _____ ☐ High Cholesterol _____ ☐ Sickle Cell Anemia _____	☐ Congenital Heart Defect_____ ☐ Diabetes Type II _____ ☐ Hypothyroidism _____	☐ Cardiomyopathy _____ ☐ Epilepsy/Seizures _____ ☐ Heart Murmur _____ ☐ Unexpected or Unexplained death before the age of 35?_____

Does your child currently take any medications? ☐Y Or ☐ N
Please list any medications with current dose (how much and how often):

Emergency medication kept at school? ☐ Y or ☐ N Please list:

Is your child allergic to any medications?☐ Y or ☐ N
If Yes, please list :

Has your child ever been pregnant? ☐Y or ☐ N

Does your child have any environmental allergies? (Ex: bees, latex, nuts, food, etc.) ☐ Y or ☐ N If Yes, please list:

Has your child had a well check within the last year? ☐Y or ☐ N

Has your child had an eye exam within the last year? ☐ Y or ☐ N

Does your child wear glasses? ☐Y or ☐ N

Dental History

Has your child had a dental exam within the last year? ☐ Y or ☐ N

Preferred Dentist:

If you have a Dental Insurance Plan different from your Primary insurance, please provide insurance carrier name and group/policy #:

Has your child been a victim of abuse or bullied? ☐Y or ☐ N Has your child seen someone abused? ☐Y or ☐ N

Do they get enough to eat? ☐ Y or ☐N

School History

Are there any learning problems/disabilities? ☐ Y or ☐ N

Are they in special classes or have IEP? ☐Y or ☐ N

I have reviewed the health history form provided by PrimaryPlus and have disclosed all my child's known health history to date. PrimaryPlus asks that you alert us if anything regarding your child's health should change throughout the year.

X_____ _____ _____

Parent or Guardian Signature Parent or Guardian Printed Name Date

CONSENT TO TREAT

Today's Date: / /	Student's Last Name:	Student's First Name:	Student's Date of Birth: / /

Physicians of: *Lewis County Primary Care Center, Inc./ DBA PrimaryPlus*

1. I, _____(parent/guardian) acting on behalf of _____(student/patient)

   who is suffering from a condition requiring medical, podiatric and/or dental care. I agree to allow this care to be received. It may include routine diagnostic and medical treatment that the attending physician(s) or others of the health center medical staff consider necessary. Services could include treatment for illness or injury including over the counter medications or necessary prescriptions, well child exams, appropriate immunizations, and appropriate behavioral evaluations--unless emergency services are needed.

2. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me about the result of examination or treatment in this health center.

3. I understand that:

   a) Normally, except under emergency or extraordinary circumstances, no important procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professionals to the patient's satisfaction.
   b) Each patient has the right to agree or refuse to agree to any proposed procedure or therapeutic course; and
   c) No patient will be involved in any research or experimental procedure without his or her full knowledge and agreement.

4. I realize that there are medical, nursing and other health care personnel at this health center who are still in training. I understand that they may be present during my care unless I request them not to be present.

5. This form has been fully explained to me, and I am satisfied, and I understand its content and significance.

6. Once the student's completed consent and history are received, PrimaryPlus can begin caring for your child for approved services during school hours. Attempts will be made to notify the parent/guardian of your child's appointment and to see if they wish to attend the visit. If no contact is made and all consents are in place, PrimaryPlus will continue the appointment as needed and contact the parent with follow-up information following the appointment including sending home a copy of the care summary.

Parent/Guardians Name (Please Print): _____

Parent/Guardians Signature: _____ Date: _____

Note: Patient/Student Signature is ONLY allowed if 18 or OLDER

I HEREBY CONSENT FOR THE FOLLOWING PERSON/PERSONS TO BRING MY UNDERAGED CHILD TO LEWIS COUNTY PRIMARY CARE CENTER, INC. dba PRIMARYPLUS FOR TREATMENT. (Please list name and relationship to child).

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

x_____ _____

Parent or Legal Guardian Signature **Date**

PrimaryPlus
www.primaryplus.net