# School-Based Health Services

Hello BlueJays!

We are so excited to be starting our FOURTH year, offering school-based health services for RULH families. We welcome you and your child to be part of our PrimaryPlus-Ripley School Based Health Center. Our sites offer students, parents, faculty, and the entire community access to primary care, dental and counseling services. PrimaryPlus is a Federally Qualified Health Center with over ten service locations throughout the region. Our health center operates year-round and during the school year we are readily available to care for your child(ren) during school hours (upon completion of consents and medical history). Parents/Guardians are always welcome at the appointments but are not required to be present as long as we have received consents and medical history.

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.

**About School-Based Medical Services:** Family Health Nurse Practitioner, Carissa Kirk, APRN, provides family health services at PrimaryPlus-Ripley. 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—although we are happy to establish care with you if you or child does not have a 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. Parents/guardians can be included in a telehealth visit of their child's appointment upon request or are welcome to be in-person for the visit.

**About School-Based Dental Services:** We are excited to continue to integrate dental care into our school-based program. Ronald Freeman, DMD has been practicing since 1983 and brings years of knowledge to our dental program. Stacie Moran, RDH is a registered dental hygienist on our Ripely team with many years of pediatric dental experience. The PrimaryPlus-Ripley dental services will include basic dental exams, cleanings, x-ray and dental sealants that will be applied to help prevent cavities. The overall goal is to ensure kids have access to dental cleanings and fluoride every six months. The dentist or dental hygienist will clean each child's teeth and the child will be given a toothbrush to take home. A Dental Report Card will also be sent home to let parents know if the child has any other dental needs. We will work closely with the school nurse for scheduling. Note: If your child has a dentist they see every 6 months for preventative dental care, please DO NOT use this program to replace your family dentist.

**Consent for School-Based Services:** 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 Wednesday, August 30th. 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 year's 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. Please feel free to contact the PrimaryPlus-Ripley team at 937-744-4343 if you have any questions. Our office hours are Monday through Friday 8 am to 5 pm.

Many Well Wishes for a Great School Year,

The PrimaryPlus Team

Quality ✚ Advanced ✚ Affordable ✚ Healthcare

Ripley Union Lewis Huntington Schools

## 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.

*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.** Note: If your child has a dental home including preventative care every 6 months, you do not need to sign up for this program. |
| _______ | **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<br>1.<br>2. | | | |
| Street Address or PO Box: | City: | St: | Zip Code: |
| Guardian Home Phone:<br>1.<br>2. | Guardian Cell Phone:<br>1.<br>2. | | Guardian Email Address:<br>1.<br>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 ☐<br>*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 | ☐ Allergies | ☐ ADHD | ☐ No Past Surgical History |
| ☐ Asthma | ☐ Autism | ☐ Anemia | ☐ Tonsillectomy Date: |
| ☐ Anxiety | ☐ Cardiomyopathy | ☐ Cerebral Palsy | ☐ Adenoidectomy Date: |
| ☐ Congenital Heart Defect | ☐ Diabetes Type I | ☐ Diabetes Type II | ☐ Appendectomy Date: |
| ☐ Concussion or Head Trauma | ☐ Gastric Reflux | ☐ Heart Murmur | ☐ Ear Tubes Date: |
| ☐ Depression | ☐ High Blood Pressure | ☐ Hypothyroid | ☐ Incision and Drainage Date: |
| ☐ Epilepsy/Seizures | ☐ Speech Disorder | ☐ Chicken Pox | ☐ Other, Please List: |
| ☐ Hernia | ☐ Meningitis | ☐ Smoking | |
| ☐ Sickle Cell Anemia | ☐ Developmental Learning/ Disorder/Delay | ☐ RSV | |
| ☐ MRSA Skin Infection | ☐ COVID-19, Date of Diagnosis ______________________ | ☐ 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_________<br>☐ Depression _________<br>☐ High Blood Pressure _________<br>☐ High Blood Pressure _________<br>☐ Pacemaker _________ | ☐ Asthma _________<br>☐ Diabetes Type I _________<br>☐ High Cholesterol ________<br>☐ Sickle Cell Anemia _______ | ☐ Congenital Heart Defect__________<br>☐ Diabetes Type II _________<br>☐ Hypothyroidism _________ | ☐ Cardiomyopathy _________<br>☐ Epilepsy/Seizures _________<br>☐ Heart Murmur _________<br>☐ 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:

## Home History

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**