SCH Shenandoah Community Health | School-Based Health

Dear Parent and/or Guardian,

Shenandoah Community Health (SCH) is pleased to partner with Berkeley County Schools to offer school-based health services in your child's school this year. This is an exciting opportunity to ensure access to healthcare and offer convenience for busy households because healthy kids make successful students!

Licensed healthcare providers will be available at the school during the days/times listed below to provide primary care services such as:

- Annual well child exams—including flu shots/vaccines, immunizations, sports physicals
- Diagnosis and treatment of chronic medical conditions
- Acute problems—including diagnosis and treatment of minor illnesses such as fever, sore throat, ear infection accidents/injuries

Our school-based health team will work in conjunction with your child's regular primary care provider (PCP), when applicable, to coordinate and enhance their overall care.

All students enrolled in the school-based health program are eligible to receive services regardless of insurance status. Shenandoah Community Health accepts most commercial insurance plans as well as Medicaid, Medicare and offers a sliding fee discount program for those who qualify; finances are never a barrier to care at SCH.

Parents are welcome to accompany their student for scheduled appointments during SBH hours. For unscheduled acute care visits, we will attempt to notify the parent if a student needs to be seen by a provider. If the parent cannot be reached, the student will be treated and given a note to take home explaining the visit. We encourage you to actively participate in your child's healthcare and are welcome to contact us anytime to discuss their care.

All parts of this enrollment packet must be completed, signed, and returned to the school or by mail to the address below before your child can receive services.

Shenandoah Community Health
Attn. School-Based Health Coordinator
P.O. Box 1146
Martinsburg, WV 25402

For questions or more information call 304.263.4999 or email schoolhealth@svms.net.

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PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / NICKNAMES(S)

SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS	BIRTH SEX (Circle One) Male Female

ADDRESS	CITY, STATE, ZIP	PHONE NUMBER

BILLING ADDRESS (If Different Than Above)	CITY,STATE,ZIP	PREFERRED CONTACT METHOD

MARITAL STATUS (Circle One)
Single Married Widowed
Divorced Legally Separated

PRIMARY LANGUAGE (Circle One)
English Spanish American Sign Language Creole Haitian Creole
Other:_____

EMERGENCY CONTACT NAME	TELEPHONE	RELATIONSHIP

PREFERRED PHARMACY	PRIMARY CARE PROVIDER

HOUSING STATUS
☐ Not Homeless ☐ Doubling Up
☐ Transitional ☐ Shelter
☐ Street

RACE
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ Other: _____

MIGRANT WORKER STATUS
☐ Migrant ☐ Seasonal

ETHNICITY
☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)
YES NO

ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
YES NO

HOUSEHOLD SIZE AND ANNUAL INCOME

NUMBER LIVING IN HOUSEHOLD: _____

HOUSEHOLD INCOME: $_____

Over

We are required by funding agencies to obtain the following information from our patients for statistical purposes. This will help us secure grants to support outreach and programs for patients with special needs. Your individual information remains private and confidential and is not shared with any agency or organization.

RESPONSIBLE PARTY INFORMATION (If Different Than Patient)		
NAME (Last, First, Middle)	SSN#	BIRTHDATE
ADDRESS	CITY, STATE, ZIP	TELEPHONE
RELATIONSHIP TO PATIENT		

PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED (EMPLOYEE, IF THROUGH WORK)		RELATIONSHIP OF PATIENT TO INSURED	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED		RELATIONSHIP TO PATIENT	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SIGN _____ **DATE** _____

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Consents

I hereby give consent for myself to receive the services of Shenandoah Valley Medical System, Inc. that does business as Shenandoah Community Health (SCH).

Patients who are unable to keep a scheduled appointment must cancel the day prior to the appointment. Appointments cancelled the day of, or not all, may subject the patient to scheduling restrictions after the third occurrence. *Does not apply to behavioral health*.

I acknowledge that I am aware SCH's "*Notice of Privacy Practices*" for protected health information is available in the waiting area of each department or on the website at shencommhealth.com. A printed copy is available by request.

I authorize staff of SCH to take my picture or scan my photo ID and place it in my Electronic Medical Record for purposes of identification. In addition, I also give consent to SCH to take photographs of rashes, endoscopy, colonoscopy, and other medical images for the purpose of medical documentation. I understand that photographs will be protected as part of my medical record and unless otherwise required by federal or state law as noted in the SCH "*Notice of Privacy Practices,*" will not be released without my authorization.

During the course of care and treatment, I understand that various types of examinations, tests, diagnostics or procedures may be necessary. This may include, but is not limited to, hearing and/or vision screening, laboratory testing, urine drug screening, injections, and other testing that the provider deems necessary. If I have any questions concerning these procedures, I will ask my clinician to provide me with additional information. I also understand my provider may ask me to sign additional Informed Consent documents related to specific procedures.

I authorize payment of insurance benefits to Shenandoah Valley Medical System, Inc. for medical services rendered to me. I understand that I am responsible for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts.

If the client is a minor, a parent/legal guardian is aware and consent to this treatment.

Patient Name	Date of Birth
Signature	Date
Parent or Legal Guardian Signature (if patient is a minor)	Date
Witness	Date

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SCHOOL-BASED HEALTH SERVICES CONSENT/ENROLLMENT

Please check Yes or No after each statement and sign at the bottom	Yes	No
I give permission for my child to be medically treated by the school-based health staff. A brief health history will be conducted during initial visit with medical provider.	☐	☐
I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school based health staff if any of my child's medical history changes.	☐	☐
Authorization for Exchange of Health & Education Information: I hereby authorize SCH to exchange health and education records with my child's school district for the purpose of providing care and treatment and educational services to my child, if applicable.	☐	☐
Authorization for Exchange of Health Information: I hereby authorize SCH to exchange health care records with my child's PCP (Primary Care Provider) for the purpose of continuity of care and treatment of my child, as needed.	☐	☐

My student's Primary Care Provider is: _____ **Phone #** _____

This authorization is valid until I revoke this authorization or until my child no longer attends this school. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. Any changes to parent/guardianship, address/phone number, or any change in medical information is my responsibility to inform SCH School Based Health Center. I recognize that health records if received by the school district may not be protected by the HIPAA Privacy Rules, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Does your student:

Have any medication/drug allergies? If so, what are they allergic to? _____

Have any other allergies we should be aware of (eggs, bees, etc)? _____

Take any medications on a daily basis? _____

Have any chronic illnesses (Asthma, Diabetes, Anemia, etc.) _____

Parentor Legal Guardian Signature	Student Signature (If over 18)
Print Name	**Date**

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The Health Center has my permission to administer, at **no charge,** the following over-the-counter medications at the discretion of the medical provider (when there has been a SBH visit). Please check:

Over the Counter Medication:	Yes	No
Tylenol		
Ibuprofen		
Hydrocortisone Cream		
Bacitracin Ointment		

The Health Center can provide your child with the required immunizations for school along with the recommended immunizations by the Center for Disease Control (CDC). These immunizations can be given, at no cost to you, through the Vaccines for Children's Program (VFC) or billed through your insurance which normally covers preventive services, i.e. immunizations, at 100%.

***** Please send a copy of your child's Immunization Record if you have it *****

Childs Name: _____ DOB: _____

I give permission for the school to share my child's immunization record with the health center for the purpose of updating my child's medical record only. (No immunizations will be given without your permission.) Yes☐No☐