JORDAN VALLEY COMMUNITY HEALTH CENTER

School Based Registration Form

Jordan Valley Community Health Center offers health care to children within schools:
Please return to your child's school nurse

Please indicate what services you would like your child to participate in:

☐ Telehealth Medical Care (Onsite all students qualify 2016-2017 school yr/ During Pilot Program Phase)
☐ Mobile Dental Unit (Insured through Mo Health Net/Medicaid or Non-insured students)
Routine check-up ☐ Toothache ☐

DATE: _____SCHOOL: _____ GRADE: _____ TEACHER: _____

CHILD'S NAME: _____
FIRST M.I. LAST

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____

STUDENTS AGE: _____ SEX: MALE FEMALE

ADDRESS_____CITY: _____ ZIP: _____

RACE: _____ PREFERRED LANGUAGE: _____

EMERGENCY CONTACT

LEGAL GUARDIAN NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____CITY:_____ZIP:_____

RELATIONSHIP: _____

HOME PHONE #: _____ WORK#:_____ CELL# _____

INSURANCE

CHILD IS COVERED BY MEDICAID: YES NO MEDICAID #: _____

OTHER INSURANCE: YES NO

NAME OF INSURANCE: _____ POLICY #:_____/GROUP #_____

INSURANCE BILLING ADDRESS: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ -_____ -_____ RELATIONSHIP: _____

CHILD'S PRIMARY DOCTOR: _____ CHILD'S PRIMARY DENTIST: _____

PHARMACY OF CHOICE: _____PHONE NUMBER _____

ADDRESS _____

(Prescriptions are not necessarily covered if not on Medicaid)

Medications
❑ **No Medications**

1._____

2._____

3._____

Allergies
❑ **No Allergies to Medications, Latex or Food**

1._____

2._____

3._____

Authorization to Release Information, Assignment of Benefits and Consent for Treatment

1. **Release of Information:** I authorize the disclosure of any or all information in my child's medical record to: Any person, corporation or agency responsible for all or part of Jordan Valley Community Health Center services who may be responsible for determining the necessity, appropriateness, payment or other matters related to Jordan Valley Community Health Center treatment or services;
   a. This includes but is not limited to, insurance companies, health maintenance organizations (HMO), preferred provider organizations (PPO), workers compensation carriers, welfare funds, Medicaid, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
   b. I further authorize Jordan Valley Community Health Center, to disclose such information to its insurance carrier or carriers when so requested by such carrier.
2. Assignment of Benefits: I assign to Jordan Valley Community Health Center the benefits due me under my insurance policy(s), Medicaid or Medicare.
3. Financial Obligation: I agree that I am financially responsible for payment of all deductibles, co-pay or con-insurance as defined in my policy or plan. I will not be responsible to pay if obligation is waived by contractual agreements between Jordan Valley Community Health Center and my insurer, or prohibited by state or federal laws or regulations.
4. Guarantor's Responsibility: I have read and I understand the financial obligations above and agree to the terms as stated.

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed about my child's health and financial information:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of Jordan Valley Community Health Center sets forth the ways in which my child's personal health information may be used or disclosed by Jordan Valley Community Health Center, and outlines my rights with respect to such information. I acknowledge that on **_____ (insert date)**

continued on next line…

_____ I am requesting a copy of the Jordan Valley Community Health Center Notice of Privacy Practices (copy will be mailed)

_____ I declined a copy of the Jordan Valley Community Health Center Notice of Privacy Practices

MY SIGNATURE BELOW MEANS:

- I have read and agreed to the above requirements and conditions.
- I give Jordan Valley Community Health Center School-Based Clinic staff permission to examine and treat my child.
- I understand that these policies apply **only** to services provided by Jordan Valley Community Health Center School-Based Clinics.
- I give permission for Jordan Valley Community Health Center School-Based Clinics, Galena R-II public school my child attends, preschool and any medical provider to share pertinent information.
- Consent to treat will be valid for one year from date of signature.
- I give Galena schools permission to transport my child to the elementary to be treated if necessary.

Legal Guardian

Printed Name: _____ Email: _____

Name: _____Date of Birth: _____/_____/_____

Signature: _____ Date: _____

Please note the federal government requires us to ask you for this information and it will be used for government reporting purposes only. Your name or any other identifying information will not be disclosed and we will not use this information for any other purpose.

Please circle your family size and the range of your annual income.

Family Size	A	B	C	D
1	$0 - $ 11,170	$ 11,171 - $ 16,755	$ 16,756 - $ 22,340	$ 22,341 or greater
2	$0 - $ 15,130	$ 15,131 - $ 22,695	$ 22,696 - $ 30,260	$ 30,261 or greater
3	$0 - $ 19,090	$ 19,091 - $ 28,635	$ 28,636 - $ 38,180	$ 38,181 or greater
4	$0 - $ 23,050	$ 23,051 - $ 34,575	$ 34,576 - $ 46,100	$ 46,101 or greater
5	$0 - $ 27,010	$ 27,011 - $ 40,515	$ 40,516 - $ 54,020	$ 54,021 or greater
6	$0 - $ 30,970	$ 30,971 - $ 46,455	$ 46,456 - $ 61,940	$ 61,941 or greater
7	$0 - $ 34,930	$ 34,931 - $ 52,395	$ 52,396 - $ 69,860	$ 69,861 or greater
8	$0 - $ 38,890	$ 38,891 - $ 58,335	$ 58,336 - $ 77,780	$ 77,781 or greater
9	$0 - $ 42,850	$ 42,851 - $ 64,275	$ 64,276 - $ 85,700	$ 85,701 or greater
10	$0 - $ 46,810	$ 46,811 - $ 70,215	$ 70,216 - $ 93,620	$ 93,621 or greater

PEDIATRIC PAST MEDICAL HISTORY

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

- ❑ ADD / ADHD ____/____/____
- ❑ Abdominal Pain ____/____/____
- ❑ Acne ____/____/____
- ❑ Allergic Rhinitis ____/____/____
- ❑ Allergies ____/____/____
- ❑ Anemia ____/____/____
- ❑ Anxiety ____/____/____
- ❑ Alcohol Abuse ____/____/____
- ❑ Asthma ____/____/____
- ❑ Autism ____/____/____
- ❑ Bronchiolitis ____/____/____
- ❑ Bronchitis ____/____/____
- ❑ Bleeding Disorders ____/____/____
- ❑ Chickenpox ____/____/____
- ❑ Concussion ____/____/____
- ❑ Constipation ____/____/____
- ❑ Cancer ____/____/____
  Type: _____
- ❑ Cystic fibrosis ____/____/____
- ❑ Dizziness/Fainting spells ____/____/____
- ❑ Diabetes ____/____/____
- ❑ Depression ____/____/____
- ❑ Eczema ____/____/____
- ❑ Fracture ____/____/____
  Location: _____ ____/____/____
- ❑ Headaches
- ❑ Hearing problems ____/____/____
- ❑ Heartburn ____/____/____
- ❑ Heart Murmur ____/____/____
- ❑ Heart Disease ____/____/____
- ❑ Hepatitis ____/____/____
  Type:_____ ____/____/____
- ❑ High Blood Pressure ____/____/____
- ❑ Kidney Disease ____/____/____
- ❑ Bladder Infections ____/____/____
- ❑ Cognitively & Developmentally Disabled ____/____/____
- ❑ Menstrual problems ____/____/____
- ❑ Migraine headaches ____/____/____
- ❑ MRSA Infections ____/____/____
- ❑ Pneumonia ____/____/____
- ❑ Prematurity ____/____/____
- ❑ Recurrent Ear Infections ____/____/____
- ❑ Seizure Disorder ____/____/____
- ❑ Sinus Trouble ____/____/____
- ❑ STD's ____/____/____
- ❑ Steroids ____/____/____
- ❑ Tuberculosis ____/____/____
- ❑ Vision Problems
- ❑ Other:
  _____ ____/____/____

SURGICAL HISTORY

Please check all that apply.

	Date		Date		Date
❑ Appendix removed	_____	❑ Adenoid removed	_____	Other:	
❑ Hernia repair	_____	❑ Ear tubes	_____	_____	_____
❑ Fracture with surgery	_____	❑ Circumcision	_____	_____	_____
❑ Dental surgery	_____	❑ Eye surgery	_____	_____	_____
❑ Tonsils removed	_____				

FAMILY MEDICAL HISTORY

Please check if any family member has had any of the following conditions. Indicate the name of the affected member, the age of onset and/or if it was the cause of death.

❑ Adopted	Mother	Father	Brother	Sister	Grandparents	Children	Cause of Death
❑ ADD/ADHD							
❑ Allergies							
❑ Asthma							
❑ Birth defects							
❑ Cancer Type: _____							
❑ DDH (hip dysplasia)							
❑ Deafness							
❑ Depression							
❑ Developmental delay							
❑ Diabetes							
❑ Genetic disorder							
❑ Heart Disease							
❑ High blood pressure							
❑ High cholesterol							
❑ Mental retardation							
❑ Migraine headaches							
❑ Obesity							
❑ Scoliosis							
❑ Seizures / epilepsy							
❑ SIDS							
❑ Thyroid Disease							
Other: _____							
Other: _____							

SOCIAL HISTORY

Resides With: _____
Child Care: _____
Smokers at home? ❑ Yes ❑ No
Outside only? ❑ Yes ❑ No
Hand Dominance ❑ Right ❑ Left

Cooperates with family/friends ❑ Yes ❑ No
Cooperates with teachers ❑ Yes ❑ No
Has enough friends ❑ Yes ❑ No
Concerns about relationship with family/friends/others ❑ Yes ❑ No

Water Type ❑ Municipal ❑ Well
Is water fluoridated? ❑ Yes ❑ No
Is there lead in home? ❑ Yes ❑ No

Home type: ❑ Apartment ❑ Condominium ❑ Duplex ❑ Single-family
Other: _____

SAFETY

Uses bike / skating helmet ❑ Yes ❑ No
Pets / animals at home ❑ Yes ❑ No
Type: _____

Smoke Detectors ❑ Yes ❑ No
Firearms in the home ❑ Yes ❑ No
Type: _____

Seatbelts ❑ Yes ❑ No
Less than 1 yr & 20lbs ❑ Carseat Face Rear
1-4 yrs & 20-40lbs ❑ Carseat Face Front
4-8yrs/40-80lbs/58in ❑ Booster Seat

LIFESTYLE

Sleep through the night ❑ Yes ❑ No
Minimum 8.5 hrs sleep nightly ❑ Yes ❑ No

Exercise / sports _____ hours per day
TV / computer games _____ hours per day

Dental History

Has your child seen a dentist before? ❑ Yes ❑ No

If yes, date of last visit and treatment received_____

Any unpleasant experiences in a dental office? _____