Springfield R-12 School District

Jordan Valley Community Health Center's Trudi's Kids Mobile Program offers Dental, Medical and Vision services to students attending scheduled sites in the Springfield R-12 Public School District.

School your child attends: _____

(Please return completed form to your child's school nurse.)

☐ ***I am providing consent for my child to participate in the following services provided by Jordan Valley Community Health Center while at school*** *(Services offered at each school may vary):*

- **Medical** - Immunizations, Sick Visits, Well Visits including Sports Physical, Telehealth
- **Dental** - Routine check-up or restorative work
- **Vision** - Eye exam (based on school nurse referral)

Date: _____ **Grade:** Select One **Teacher:** _____

Child's Name: _____

First *M.I.* *Last*

Social Security Number: _____ **Date of Birth:** _____

Student's Age: _____ **Sex:** ☐ Male ☐ Female **Preferred Language:** Select One

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

You may choose to decline to answer the following two questions:

Race: Select One **Ethnicity:** Select One

Child's Primary Doctor: _____

Child's Primary Dentist: _____

Preferred Pharmacy: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT

Legal Guardian Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Relationship to Child: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell #:** _____

INSURANCE

Child is covered by Medicaid: ☐ Yes ☐ No **Medicaid #:** _____

Child is covered by other insurance: ☐ Yes ☐ No **Policy #:** _____ **Group #:** _____

Name of Insurance: _____

Billing Address: _____

Name of Policy Holder: _____ **Date of Birth:** _____

Social Security Number: _____ **Relationship:** _____

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

- **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.
    - 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.
    - I further authorize Jordan Valley Community Health Center, to disclose such information to its insurance carrier or carriers when so requested by such carrier.
- **Assignment of Benefits:** I assign to Jordan Valley Community Health Center the benefits due me under my insurance policy(s), Medicaid or Medicare.
- **Financial Obligation**: I agree that I am financially responsible for payment of all deductibles, co-pay or co-insurance as defined in my policy or plan. Jordan Valley reserves the right to bill for treatment on uninsured/underinsured patients. Before doing so, the parent/guardian will be contacted with a cost estimate of necessary treatment.
- **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)**

☐ I am requesting a copy of the Jordan Valley Community Health Center Notice of Privacy Practices (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, **_____** the public school my child attend, Head Start and any medical provider to share pertinent information.
- I understand that consent to treat will be valid for one year from date of signature.
- I understand that all of JVCHC dental locations are a clinical teaching site for dental residents and dental students. My dental treatment may be provided by a dental resident or dental student under the supervision of clinical teaching staff.
- I have been informed there are some risks inherent in all dental procedures including the administration of local anesthesia and/or nitrous. I am aware that the risks are essentially the same as those procedures performed in a private dentist's office (possible allergic reaction to anesthetic drug, possible accidental cuts or abrasions). Further, I certify that I understand and agree to the conditions set forth above. I also understand I am free to ask any questions regarding the procedures and risk involved.
- I understand it is my responsibility to give a complete and truthful medical history including all medications, medical conditions, allergies, drug use, pregnancy, surgeries, etc.
- I understand it is my right to opt out of any specific vision, medical, and dental services that I do not want my child to receive and have listed them here: _____

Legal Guardian

Printed Name: _____ **Email:** _____

Signature: _____ **DOB:** _____ **Date:** _____

Please select your family size and the corresponding range of your annual household income.

- *Please note that 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.*

Number of family members: Select One **Annual Household Income:**

PEDIATRIC MEDICAL HISTORY

Child's Current Medications

☐ No Medications

1. _____
2. _____
3. _____

Allergies

☐ No Allergies to Medications, Latex or Food

1. _____
2. _____
3. _____

Please indicate if your child has ever experienced any of the following conditions. Please include the date.

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

Type: _____

SURGICAL HISTORY

	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? Name of Deceased
□ ADD/ADHD							□ Yes □ No _____
□ Allergies							□ Yes □ No _____
□ Asthma							□ Yes □ No _____
□ Birth Defects							□ Yes □ No _____
□ Cancer Type: _____							□ Yes □ No _____
□ DDH (hip dysplasia)							□ Yes □ No _____
□ Deafness							□ Yes □ No _____
□ Depression							□ Yes □ No _____
□ Development Delay							□ Yes □ No _____
□ Diabetes							□ Yes □ No _____
□ Genetic Disorder							□ Yes □ No _____
□ Heart Disease							□ Yes □ No _____
□ High Blood Pressure							□ Yes □ No _____
□ High Cholesterol							□ Yes □ No _____
□ Mental Retardation							□ Yes □ No _____
□ Migraine Headaches							□ Yes □ No _____
□ Obesity							□ Yes □ No _____
□ Scoliosis							□ Yes □ No _____
□ Seizures/Epilepsy							□ Yes □ No _____
□ SIDS							□ Yes □ No _____
□ Thyroid Disease							□ Yes □ No _____
Other _____							□ Yes □ No _____
Other _____							□ Yes □ No _____

SOCIAL HISTORY

Who does the child live with: _____ Cooperates with family/friends Yes No

Child Care: _____ Cooperates with teachers Yes No

Smokers at home? _ Yes _ No Has enough friends _ Yes _ No

If yes, do they smoke outside only? Yes No Concerns about relationship with family/friends/others Yes No

Hand Dominance Right Left

Water Type Municipal Well Home type: Apartment Condominium

Is water fluoridated? Yes No Duplex Single Family

Is there lead in home? Yes No Other: _____

SAFETY

Uses bike/skating helmet Yes No Smoke Detectors in home Yes No Wears a seatbelt Yes No

Pets/animals at home Yes No Firearms in home Yes No Less than 1 yr/20 lbs. Car seat faces rear

Type: _____ Type: _____ 1-4 yrs/20-40 lbs. Car seat faces front

4-8 yrs/40-80 lbs./58 in. Booster Seat

LIFESTYLE

Sleeps through the night _ Yes _ No Exercises/Plays Sports _____ hours per day

Minimum of 8.5 hours of sleep nightly Yes No Watches TV/Plays Video Games _____ hours per day

OPTOMETRY

Does your child need a routine check-up? Yes No Does your child have vision problems? Yes No

If yes, what kind of problems is your child experiencing? _____

Has your child seen an eye doctor before? Yes No

If yes, date of last exam _____

Has your child ever worn glasses? Yes No Has your child ever worn contacts? Yes No

DENTAL

Has your child seen a dentist before? Yes No

If yes, what is the date of their last treatment received? _____

Has your child had any unpleasant experiences in a dental office? _ Yes _ No

If yes, please describe what happened _____

_____

Please return completed form to your school nurse.