COPLIN HEALTH SYSTEMS
Jackson County Schools Wellness Center

562 Charleston Drive
Ripley, WV 25271
Phone: 304-372-7341 Fax: 304-372- 3272

STUDENT INFORMATION *

Student Name: _____ Student SS #: _____
Address- City: _____ Pharmacy: _____
State/Zip: _____ Email: _____ School: _____
Phone: _____ Cell: _____ Grade: _____ Birth date: _____

Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:* _____

PARENT / GUARDIAN INFORMATION

Father: _____ (email) _____
Phone (H)_____ (W)_____ (C) _____
Mother: _____ (email) _____
Phone (H)_____ (W)_____ (C) _____
Mother's Maiden Name:_____
Guardian: _____(email) _____
Phone (H)_____ (W)_____ (C) _____

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Name: _____ Relationship: _____May we leave a message? __ Y __N
Phone: (Home) _____ (Work) _____ (Cell) _____

Health Information *(Additional health, family & developmental history may be collected by your site)*

1. Doctor's name / phone number: _____
2. Name of Dentist: _____
3. If we need to call in a prescription, which pharmacy would you like us to call? _____
4. Immunizations:
   - ☐ I give my permission for you to obtain my child's immunization record
     Signature: _____Date:_____

INCOME INFORMATION – Please complete all that apply. **Please Circle the Following:**

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9
What is your estimated household monthly net income?
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000
My child qualifies for free or reduced lunch _____ Yes _____ No

Sliding Scale Fee information

Even if you have health insurance, this program may help you with the cost of health care at our facility. This program is offered through Coplin Health Systems and may pay a portion of the costs for office visits at the Jackson County Schools Wellness Center. Families with insurance may qualify for deductible and co-pay discounts. Documentation required includes a Jackson County Schools Wellness Center enrollment and consent form, a completed sliding fee scale application with proof of total family income, and a copy of your most recent tax return.

☐ **No health insurance / Request application for sliding fee / CHIP / Medicaid**

IF NO INSURANCE SKIP TO CONSENT PAGE

INSURANCE INFORMATION – Please complete all that apply

Responsible Party_____ Relationship_____

Child's Insurance Information – *Please check all that apply and send a copy of your insurance card(s)*

☐ **Primary Health Insurance:**
Name of Insurance Company _____
Group # _____ ID # _____
Insurance Address _____
Insurance Phone / Fax Number _____
Name of Insured Parent / Guardian_____
Birthdate of Card Holder_____ SSN of Card Holder _____
Address (if different from child):

_____
Place of Employment _____

☐ **Secondary Health Insurance**:
Name of Insurance Company _____
Group #:_____ ID #_____
Insurance Address_____
Insurance Phone / Fax Number _____
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____

_____

☐ **Medicaid: Unisys Unicare Carelink Health Plan WV Family Health (please circle one)**
Medicaid ID#: _____ Member ID# _____
PCP/HMO Provider: _____ Provider Phone Number: _____

☐ **CHIP:** Name on Card: _____ Birth date of card holder: _____
ID or PIN # on card: _____ Group #: _____

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at Jackson County Schools Wellness Center (SBHC). I understand that this consent form will be good until my child leaves/ graduates school or until I provide the Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving the SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided.

When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Signature of Witness (this can be anyone) Date

HIPAA OF 1996 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Jackson County Schools Wellness Center's health care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. A copy of HIPAA privacy practices for the parent/guardian of the student receiving medical, dental or mental health counseling services at Jackson County Schools Wellness Center is provided upon initial visit or is available upon request from the Jackson County Schools Office of Health Services. The Notice of Privacy Practices is also posted in the waiting areas.

HEALTH HISTORY FORM

NAME:_____ **BIRTHDATE:** _____

FAMILY DOCTOR:_____ **PHONE:** _____

DENTIST: _____ **PHONE:** _____

MEDICATIONS TAKEN DAILY OR AS NEEDED BASIS

Medication_____ Dose(mg) _____ Directions: _____

Medication_____ Dose(mg) _____ Directions: _____

Medication_____ Dose(mg) _____ Directions: _____

Medication_____ Dose(mg) _____ Directions: _____

ALLERGIES

Medication(s): _____

Food: _____ Other:_____

Does the child have an order for and carry any of the follow: Check all that apply:

_____ Epi Pen _____ Insulin _____ Glucagon

MEDICAL HISTORY

List Chronic or Intermittent Disease or Health Problem (example, Diabetes, Asthma, High Blood Pressure, Sinus Infections)

_____

_____

_____

SURGERY

List the type and date of the operation. (example, tonsils – Sept 2005)

_____

_____

SERIOUS INJURY OR ACCIDENTS

List type of accident and resulting injury and the date. (example, Football accident, broken right lower leg, Oct. 2008)

_____

_____

SOCIAL HISTORY

Tobacco Use: Yes: _____ Number of Packs per day NO

Alcohol Use: Yes: _____ Number of drinks per day. NO

Caffeine Use Yes NO

If you answered, Yes to caffeine use: check all sources that apply.

Sweet Soda Pop - Number per day _____ Diet Soda Pop Number per day _____ Tea Number per day _____
Coffee - Number per day _____ Chocolate - Number per day _____

Street Drug Use: Yes Name of Drug(s)_____ NO

FAMILY MEDICAL HISTORY: List disease by the appropriate family member.

Mother:_____

Father: _____

Sister: _____

Mom's Mother _____

Mom's Father_____

Dad's Mother _____

Dad's Father _____

The information I have given is correct to the best of my knowledge. I understand that my medical information will remain confidential and it is my responsibility to inform the Wellness Center Staff of any changes in medical care and status.

_____ _____

Parent/Guardian Signature **Date**

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OTHER SERVICES WE OFFER

Sports Physicals

Sports Physicals are provided year round at the Wellness Center and by appointment during scheduled weeks in the summer.

Well Child Exam

Insurance will pay for one Well Child Exam per year. If you would like your child to have this exam provided by the Wellness Center, **please call our office and schedule the appointment**. The exam is based on the age of the child. We check hearing, basic vision screening, scoliosis, and assess if vaccines are current as well as a physical exam. Referrals are made as needed based on the outcome of the exam. It is helpful if a parent accompanies the child during this visit as there are questions the child may not be able to answer (especially if child is below 5th grade school level).

☐ **Yes I would like my child to receive a Well Child visit**

School Based Behavioral Health Services

We are excited to announce that we have begun offering School Based behavioral health services at Ravenswood High School for Ravenswood High School students. If you have an interest in seeking these services, please see the School Counselors at Ravenswood High School for more information.

Behavioral Health Services:

We are excited to announce that we have begun offering Behavioral Health and Substance Abuse Services at Ripley Family Care and River Valley Family Care in Ravenswood. These services are available for patients of any Coplin Health Systems sites. All ages are accepted, depending on their insurance. If you are interested in receiving behavioral health &/or substance abuse services, please contact the Wellness Center at 304-372-7341, Ripley Family Care at 304-372-1033, or River Valley Family Care at 304-273-1033.

Portable Dental Unit

The portable dental unit visits schools twice a year for dental exams, fluoride treatments, cleaning and sealants. Services utilized through the Portable Dental Unit will be billed to your insurance. If you do not have dental coverage, or your coverage doesn't pay, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of this form. **To enroll in the portable dental clinic, please complete The Portable Dental Enrollment Unit Form.** Referral to outside dentists may be necessary for additional or more comprehensive dental work. These referrals are not part of the portable dental unit. The parent or guardian is responsible for making payment arrangements with the referring dentist.

☐ **Yes, I would like my child to receive Portable Dental Services. My child does not have a dentist. PLEASE COMPLETE PORTABLE DENTAL ENROLLMENT FORM ON THE NEXT PAGE.**

☐ **No, my child already has a dentist. NAME OF CURRENT DENTIST** _____

☐ **No, my child does not have a dentist but I do not want my child to have these services.**

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Portable Dental Unit Enrollment Form

The portable dental unit will be at your child's school at least twice during the school year. The first visit will be during September and again in the spring. In order to schedule appointments in a timely manner, please return form to the school as soon as possible. **Please note, if your child has an appointment and the forms are not signed and returned, the appointment will be cancelled. If your child is going to another dentist and does not need these services, please notify the Wellness Center that your child does not need these services.**

Services will be billed to your insurance. If you do not have coverage, or your insurance doesn't pay, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of the enrollment and consent form.

If your child already has a dentist, then they do not qualify for this program. Your insurance will not cover the fees of your regular dentist and this program.

Name of Child _____ Date of Birth _____

Name of Current Dentist:_____

If your child does not have a regular dentist and you would like your child to participate in the portable dental program, Please complete enrollment and consent form for Wellness Center Services sent home with your child and the following information.

Does your child have Dental Insurance? No Yes Name of Company _____

Address: _____ Phone: _____

Effective Date: _____ Policy Number:_____ Group Number: _____

Subscribers name:_____ Birth date: _____ SS#_____

Subscribers Address: _____

Employer: _____

Medicaid: Yes or No Copy of card required. Carelink Unisys Unicare Health Plan WV Family Health

Family Case Number: _____ Child's Number:_____

Primary Care Provider listed on the Card: _____

May we leave a message on your phone with the date and time of your child's appointment if you are not available to take the phone call with the appointment information? Yes No

I, the parent or guardian of _____, give consent for him/her to participate in the portable dental service and confirm by my signature this does child does not already have a dentist.

_____ _____

Signature Date

JCSBW 7