Lebanon R-3 School District

Jordan Valley Community Health Center's Trudi's Kids Mobile Program offers Dental, Medical, Vision and Therapy Services to students attending scheduled sites in the Lebanon R-3 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 *(Please select all that apply):*

- □ **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)
- □ **Therapy Services** - Occupational Therapy, Physical Therapy, Speech Language Therapy

Date: _____/____/_____ **Grade:** _____ **Teacher:** _____

Child's Name: _____

First *M.I.* *Last*

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

Student's Age: _____ **Sex:** □ Male □ Female **Preferred Language:** _____

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

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

Race: _____ **Ethnicity:** _____

(EX: Black/African American, American Indian, Asian, Hawaiian, Hispanic, Multi-Racial, White, etc.) *(EX: Not Hispanic/Latino, Hispanic/Latino, Unknown, Other, etc.)*

Child's Primary Doctor: _____

Child's Primary Dentist: _____

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

Pharmacy Address: _____

LEGAL GUARDIAN/GUARANTOR 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 Valle 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: _____

Signature: _____ **DOB:** ___/___/____ **Date:** ___/___/____

Email Address: _____

Please circle 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.*

Family Size	A	B	C	D	E
1	$0 - $12,880	$12,881 - $19,320	$19,321 - $22,540	$22,541 - $25,760	$25,761 or greater
2	$0 - $17,420	$17,421 - $26,130	$26,131 - $30,485	$30,486 - $34,840	$34,841 or greater
3	$0 - $21,960	$21,961 - $32,940	$32,941 - $38,430	$38,431 - $43,920	$43,921 or greater
4	$0 - $26,500	$26,501 - $39,750	$39,751 - $46,375	$46,376 - $53,000	$53,001 or greater
5	$0 - $31,040	$31,041 - $46,560	$46,561 - $54,320	$54,321 - $62,080	$62,081 or greater
6	$0 - $35,580	$35,581 - $53,370	$53,371 - $62,265	$62,266 - $71,160	$71,161 or greater
7	$0 - $40,120	$40,121 - $60,180	$60,181 - $70,210	$70,211 - $80,240	$80,241 or greater
8	$0 - $44,660	$44,661 - $66,990	$66,991 - $78,155	$78,156 - $89,320	$89,321 or greater
9	$0 - $49,200	$49,201 - $73,800	$73,801 - $86,100	$86,101 - $98,400	$98,401 or greater
10	$0 - $53,740	$53,741 - $80,610	$80,611 - $94,045	$94,046 - $107,480	$107,481 or greater

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 & Developmentally Disabled	___/___/_____
☐ Abdominal Pain	___/___/_____	☐ Dizziness/Fainting spells	___/___/_____		
☐ Acne	___/___/_____	☐ Diabetes	___/___/_____		
☐ 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							
□ Allergies							
□ Asthma							
□ Birth Defects							
□ Cancer							
Type: _____							
□ DDH (hip dysplasia)							
□ Deafness							
□ Depression							
□ Development 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

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

Outside only? □ Yes □ No Concerns about relationship □ Yes □ No

Hand Dominance □ Right □ Left With family/friends/others

Water Type □ Municipal □ Well Home type: □ Apartment □ Condominium

Is water fluoridated? □ Yes □ No □ Duplex □ Single Family

I 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.