T·J·Health School-Based Medicine Program

METCALFE COUNTY SCHOOL YEAR 2022-2023

PARENTS: *Please complete the following information about your child.*

STUDENT INFORMATION

Metcalfe School: ❑ Elementary ❑ Middle ❑ High

Grade Level:_____

Legal Name:_____
First *Middle* *Last*

Child's Last Name at Birth:_____

Preferred Name:_____

Date of Birth:_____

Social Security Number:_____

Mother's Name:_____
First *Last*

Father's Name:_____
First *Last*

Address:_____

City, State, Zip:_____

Home Phone:_____

Cell Phone:_____

Who is legal guardian?_____
If foster child, list social worker's name.

Guardian's Date of Birth:_____

Parent/Guardian Work Number:_____

Email Address:_____

Emergency Contact:_____

Emergency Contact's Number:_____

Relationship to Child:_____

DEMOGRAPHIC INFORMATION

Sex:
❑ Male ❑ Female

Language:
❑ English ❑ Spanish ❑ Other:_____

Race:
❑ American Indian or Alaskan Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Pacific Islander
❑ White
❑ Decline to respond

Ethnicity:
❑ Hispanic ❑ Non-Hispanic ❑ Other

PROVIDER & PHARMACY INFORMATION

Primary Care Provider:_____

What pharmacy do you use?_____

City:_____

Pharmacy Phone:_____

MEDICAL INSURANCE INFORMATION

If your child has Medicaid care, KCHIP card, or private insurance, please complete the information below. The insured guardian will be responsible for any additional amount due after insurance benefits have been applied.

Insurance Company Name:_____

Insurance Company Address:_____

_____

_____

Insurance Company Phone:_____

I.D. Number:_____

Group Number:_____

Name of Insured:_____

Date of Birth of Insured:_____

Relation to Patient:
❑ Spouse ❑ Child ❑ Other

CONSENT FOR SCHOOL RECORD

I give consent to T.J. Regional Health staff to review my child's school record, including attendance and other information, if applicable, that will assist the staff in caring for my child. I understand that T.J. Regional Health shall provide a copy of its Notice of Privacy Practices upon my request, which is also available at www.tjsamson.org.

_____
Print Parent/Guardian Name

_____
Parent/Guardian Signature

_____
Date

Rev. 3/24/2022

METCALFE STUDENT HEALTH HISTORY

FAMILY HISTORY

Please label below with **C** for Child, **M** for Mother, **F** for Father, **S** for Sibling, an **G** for grandparent.

Does your child or the child's immediate family have a history of:

___No Problems
___Asthma
___Diabetes
___Heart Murmur/Congenital Heart Defect
___High Blood Pressure
___Anemia
___Thyroid Problems
___Epilepsy / Seizures
___Gastric Reflux
___Frequent Ear Infections

___Urinary Problems
___Tonsils / Adenoids Removed
___Ear Tubes
___Hernia
___Frequent Sore Throats
___Eye Problems / Wears Glasses
___Kidney Disease
___ADHD
___Depression/Anxiety/Mood Disorder
___Development Learning Problems

___HIV/AIDS
___Hepatitis A, B, or C
___Other (please list):
_____
_____

Has your child had any of the following diseases:

❑ Chickenpox
❑ Meningitis
❑ RSV

MEDICATIONS

Does your child currently take any medications? ❑ Yes ❑ No

Please list any medications with current dose (how much and how often):_____

_____

ALLERGIES

Is your child allergic to environmental factors (bees, latex, nuts, food, etc.) or medications? ❑ Yes ❑ No

Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.): *Please provide a statement from provider.*

Name of Allergen and Type of Reaction

_____

_____

_____

ASSIGNMENT OF BENEFITS

I request that payment of authorized medical insurance benefits be made to T.J. Regional Health on my child's behalf for services received. I also authorize them to release medical information about my child to Medicaid or my insurance company to determine payment for services.

CONSENT TO TREAT

I consent to the medical care of my child which may include screening, exam, lab tests, treatment, medicine, and any other health service given to me by staff in the T.J. Health School Based Medicine Clinic.

Please read carefully, COMPLETE FORM, SIGN, and DATE. Student should return this form to their homeroom teacher. Please notify your T.J. Health School-Based Medicine Clinic if there are any health changes or a change in guardianship. Consent will not expire until your child leaves the District or the T.J. Health School Based Medicine Clinic is notified in writing that you wish to revoke such.

I give my consent for my child to receive the following services at the T.J. Health School-Based Medicine Clinic.

_____ _____ _____
Student's Full Name *Date of Birth* *Social Security Number*

PLEASE INITIAL TO GIVE YOUR CONSENT:

____**All Services**

____**School Nurse Services** *(Includes illness assessment and emergency medication administration)* Medication to be given:

____Tylenol ____Antibiotic Ointment ____Motrin / Advil ____Aloe Vera ____Cough Drops
____Benadryl ____Anti-itch cream ____Claritin (for allergies) ____Sunscreen ____Benzocaine Spray
____Anti-nausea ____Milk of Magnesia ____Cough Syrup (Tussin DM)

____**Nurse Practitioner Services/MD** *(Parent/guardian will be notified prior to visit). Billed to insurance.*

____**Sick Visits** (cold, flu, strep, stomach virus, ear infections, etc.) Includes tests for strep, flu, mono, lab work and antibiotic/steroid injections *(with provider order and parental/guardian consent)*, basic wound care, suture/suture removal *(with parental/guardian consent). Billed to insurance. Guardian will be responsible for remaining balance after insurance payment.*

____**No services at this time**

SIGNATURE REQUIRED: _____ _____ _____
Parent / Guardian Signature *Printed Name* *Date*