Valley-Wide Health Systems, Inc.

School Based Health Enrollment Form

PATIENT INFORMATION Childs Legal Name

_____

(Last) (First) (M.I)

_____

(Birth Date) Sex: Male ◯ Female ◯

_____

Parent or Guardian Name (Parent/Guardian Birth Date)

_____

Billing Address City

_____

State Zip

_____

Secondary Address City

_____

State Zip

(____)_____(_____)_____

Primary Phone Secondary Phone

_____

E-mail Address

_____(_____)_____

Emergency contact name Phone

_____(_____)_____

Guarantor (person responsible for payment) Phone

_____

Guarantor Address

Preferred Language _____

Homeless Yes ◯ No ◯

Do you reside in public housing Yes ◯ No ◯

Race

White ◯ Asian ◯
Black/ African American ◯
Other ◯ Refused ◯
Unknown ◯

Ethnicity

Hispanic or Latino ◯
Not Hispanic or Latino ◯
Other ◯ Refused ◯
Unknown◯

MEDICAL INFORMATION

Primary Medical Provider:_____

Primary Dental Provider:_____

Dose your child see a doctor for regular check ups. YES ◯ NO ◯

When was the last time your child saw a dentist? ◯ Never

◯ Over 5 years ◯ 3-5 years ◯ 1-3 years ◯ less than a year

Medical Insurance Name:_____

Policy Number:_____

Group Number:_____

Dental Insurance Name:_____

Policy Number:_____

Group Number:_____

Would you be willing to provide the following information?

Yes ◯ No ◯

Family Size_____ Monthly income $_____

Why do we ask? We are a federally Qualified Healthcare Center (FQHC). Our federal funding that we receive to enhance our services is based off these numbers.

Are you or a family member a agricultural worker?_____

In the last 24 months have you or a member of your family

Been hired to do agricultural (Ag) work ? Yes ◯ No ◯

Is the majority of your income from Ag work ? Yes ◯ No ◯

Moved temporarily to do Ag work? Yes ◯ No ◯

Have you stopped working in Ag due to age or disability? Yes ◯ No ◯

Valley-Wide Health Systems, Inc.

Parental Consent

School-Based Health Services

I give my consent for _____ _____
Child First Middle Last Name Child's Birth Date

to receive necessary and/or advisable health services from Valley-Wide Health Systems, Inc. (VWHS) staff at the Canon City School-Based Health Center (CCSBHC). I have received information explaining VWHS services at the CCSBHC, I understand the following services may be available and by checking the corresponding box next to each service type I consent for my child to receive these services:

☐ **Medical Services:** Physical exams and immunizations · Routine lab tests · Care for acute illness and injury · Prescription medications · Care of certain chronic conditions such as asthma and seizure disorder · pregnancy testing · diagnosis and treatment of STD/STI · Age-appropriate reproductive health services · Drug and alcohol prevention and education · Behavioral health assessment and referral to treatment · Follow-up care as needed

☐ **Dental Services:** Dental screenings, routine cleanings, sealants, and dental x-rays

Release of Information: The information in my child's medical record is protected health information and will not be released to any unauthorized person or agency without written consent by child's parent/guardian. I understand that CCSBHC may disclose health information for payment, treatment, and health care operations as described in VWHS's Notice of Privacy Practices, and otherwise as allowed by law. As allowed by Colorado law, my son or daughter may request that certain visits and health information remain "confidential." This means that, for me or any other part to have access to my child's medical records regarding such information, a written release must be completed by my child. I give permission for the CCSBHC staff to examine and/or copy my son's or daughter's school records including immunization records attendance, and other records that may assist the staff in helping my son or daughter.

CCSBHC Fees, billing, authorization, and consent: I hereby authorize payment directly to Valley-Wide Health Systems, Inc. for medical/dental benefits. I understand that I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I understand that if I have been issued a refund check and it is returned as undeliverable after reasonable attempts to contact have been unsuccessful, such check will be considered a donation to VWHS. I also agree that if I fail to cash a refund check within 1 year of issuance, the refund check will be considered as a donation to VWHS.

☐ I do not give consent for my child _____,
Child's First Middle Last Name

DOB _____ to receive any necessary and/or advisable health services
Childs Date of Birth

from Valley-Wide Health Systems, Inc. (VWHS) staff at the CCSBHC.

_____ _____
Parent/Guardian Signature Date

Valley-Wide Health Systems, Inc.

SCHOOL BASED HEALTH QUESTIONNAIRE

_____

Child's First Name Last Name Date of Birth

Does your child take any medications? ____ Yes ____ No If yes, please list:

Name of Drug	Strength	Frequency Taken

Does your child have allergies? Yes No If yes, please list along with reaction:

_____

Does or did your child have any of these problems now or in the past? Please circle.

Asthma	Heart Disease	Migraines
Birth Problems	High Blood Pressure	Diabetes
Blood Clots/Stroke	Development/Learning Delays	ADHD
Cancer	Behavioral-Mental Illness	Depression
Chicken Pox	Sickle Cell Anemia	Heart Murmur
Pins/Broken Bones	Eating Disorder	Drug/Alcohol Abuse
Seizures	Tobaccos Use	Stomach/GI Disorder

Other:

_____

Has your child been hospitalized overnight or had surgery or any serious injuries? If yes, please list:

_____

Does anyone in your family (parents, siblings, grandparents, aunts/uncles) have any of these problems, now or in the past?

Asthma……if yes, who? _____
Blood Clots/Stroke……if yes, who? _____
Cancer……if yes, who? _____
Diabetes……if yes, who? _____
Drug/Alcohol Abuse……if yes, who? _____
Heart Disease……if yes, who? _____
High Blood Pressure……if yes, who? _____
High Cholesterol……if yes, who? _____
Mental Illness/Depression……if yes, who? _____
Sickle Cell Anemia……if yes, who? _____
Tuberculosis/TB……if yes, who? _____

How many days of the week does your child engage in physical exercise _____

Is the child currently pregnant ____No ____Yes