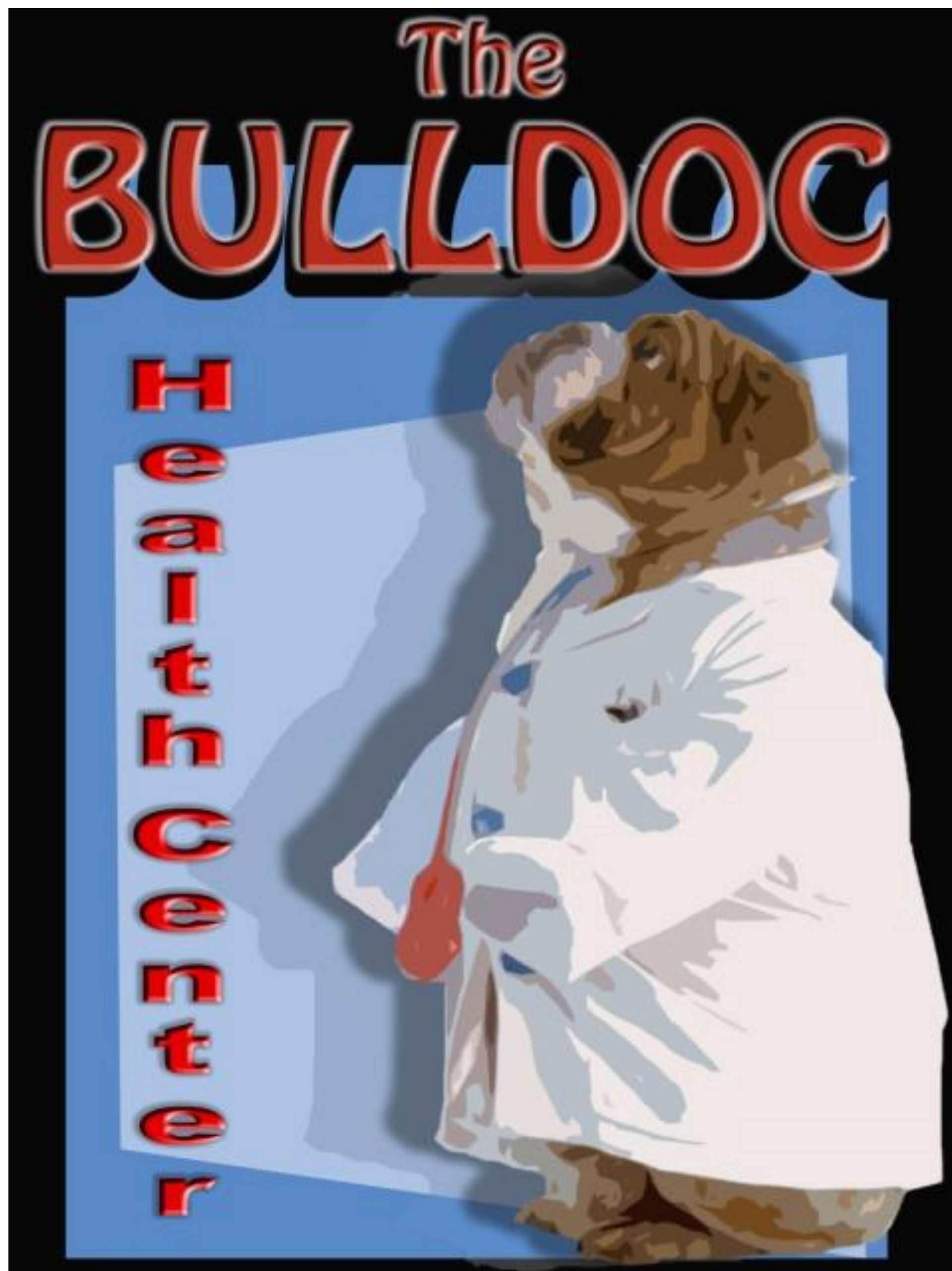
Bulldoc Registration



USD 500 School-Based Health Center
ENROLLMENT FORM

Dear Parent or Guardian:

The goal of the School-Based Health Center (SBHC) is to address the overwhelming health need in Wyandotte County by providing health care to students within a fixed site on a school campus. The SBHC aims to improve the health and overall well-being of students and families, as well as increase the academic success of Wyandotte County adolescents.

What is the USD 500 School-Based Health Center?

- The SBHC will be run by the University of Kansas Medical Center as well as Wyandotte County community volunteers
- The purpose of this center is to deliver high quality and convenient healthcare to students at Wyandotte High School

How do I register my child?

- Please fill out the attached forms and return them to your school office. The enclosed forms include:
  - Consent Forms
  - Registration Form
  - Health History and Parent Questionnaire
- Also please include a copy of your child's health insurance card if applicable
- Once enrolled, your child can be seen at any time during their years attending Wyandotte High School/Northwest Middle School

What happens after I register?

- By completing the forms, your child may be seen at the SBHC during the open hours for any health concerns

Thank you,
The SBHC Team

Please return this form to the office at Wyandotte High School. Please do not give this form to your child's teacher or other school staff.

USD 500 SCHOOL-BASED HEALTH CENTER
Consent Form

SERVICES

Services offered at the USD 500 School-Based Health Center will focus on prevention and involve standard of care health practices, including:

- Evaluation and treatment of acute and chronic health problems
- Sports physicals
- Immunizations (including flu shots)
- Health education
- Coordination of care with other health providers
- Coordination and communication with student parents and families as appropriate for health promotion
- Dental and vision screenings
- Mental health services and referral
- Referral and case management for resources such as food, shelter, financial issues, transportation
- Preventive care

Our relationship with the patients and their parents is very important. We strongly encourage and welcome the involvement of parents and guardians.

Participation in the SBHC is voluntary, and you may withdraw permission at any time in writing.

I have reviewed and understand the services offered. I give consent for my child to receive the services indicated on this document. By signing this consent form I certify that I am the legal guardian and legal custodian of:

____

Student Name (*please print)*

I understand this consent will remain valid until my child graduates and that I may withdraw my consent for services upon written notice to the Wyandotte High School SBHC at any time.

I understand all SBHC medical records are part of the KUMC electronic medical records system.

I further authorize the SBHC to release information only to 1) school staff when needed to coordinate services at school, 2) third party payers or others for the purpose of receiving payment for services.

____ ____________________

Parent/Guardian Signature ***Date***

USD 500 SCHOOL-BASED HEALTH CENTER
Consent Form

IMMUNIZATION CONSENT

I understand that my child's immunization (shot) records from school district files and the University of Kansas Medical Center will be reviewed. ***If it is determined that my child needs a shot, I give my permission for it to be given at the Wyandotte High School SBHC.*** *If I do not want the shot given to my child, I need to call or send a letter to the SBHC before the planned shot day. I understand a letter with the needed shot and a Vaccine Information Sheet will be sent home for my review at least 1 week before the immunization is planned to be given.*

Please check one

□ Yes, I agree □No, I do not agree Parent/Guardian Signature ________________________

MEDICATION CONSENT

I understand that Acetaminophen (ex. Tylenol) and Ibuprofen (ex. Advil or Motrin) are available at the health center to relieve minor discomforts of headache, in school injury, menstrual cramps, or of dental procedures (braces, etc.). If my child has one of those complaints I give my permission to administerthe medication noted below in the age appropriate dose.

□ Yes, I agree. Please check one or both: _____ acetaminophen _____ ibuprofen

□ No, I do not agree

Parent/Guardian Signature ________________________

We will contact you if minor discomforts occur frequently and/or are a concern to our medical staff. This permission will remain in effect unless otherwise revoked in writing.

PHOTO CONSENT

I understand that on occasion the SBHC uses photographs of school and health center activities in materials that are circulated to the public. These photographs may include students. I give permission to the SBHC to include photopraphs of my child in these materials.

Please check one

□ Yes, I agree □No, I do not agree Parent/Guardian Signature ________________________

USD 500 SCHOOL-BASED HEALTH CENTER
Student Registration Form

Please check which school your child attends:

□ Wyandotte High School
□ Northwest Middle School

Today's Date __________________ School _____________________________________ Grade __________________

Name: ____ ____
Last First

Date of Birth: _________________ Primary Language Spoken at Home: ______________________ □ Needs Interpreter

What name does your child like to use? _______________________ Gender: □ Male □Female

Address ____

City ____ State _______________________ Zip __________________

Ethnic Group: □ American Indian □ African American □ Hispanic □ Caucasian □ Asian □ Middle Eastern
Multi-racial (please specify): _______________________________
Other (please specify): ____________________________________

Parent / Guardian Name (if child is under 18): ____

Home phone: _____________________ Cell phone: _____________________ Work phone: _____________________

Best way to reach during the school day? (please "x") Home____ Cell____ Work____ Other_____

Emergency Contact Name: (If parent/guardian not available): ____
Relationship to child: __________________________ Phone Number: ________________________________

Do you have health insurance? □ No □ Yes (please check which carrier below):

□ Medicaid: Type/Policy #: ____

□ Other insurance: ____

Subscriber's name: _______________________________________ Subscriber's Date of Birth: ____________________

Policy # ____ Group # ____

Pharmacy Name: ______________________________________ Phone Number: _______________________________

Does your child have a Primary Care Provider (PCP)? □ Yes □ No
If yes, Name of PCP: _______________________________________
Date of last complete physical exam __________________________
Does your child have a Dentist? □ Yes □ No
If yes, Name of Dentist: ____________________________________

Adults in the family

Name:	Occupation	Relationship	In home (yes/ no)
___________________________	___________________________	____________________	___________________
___________________________	___________________________	____________________	___________________

Children in the family

Name:	School	Relationship	In home (yes/ no)
___________________________	___________________________	____________________	___________________
___________________________	___________________________	____________________	___________________

USD 500 SCHOOL-BASED HEALTH CENTER
Health History and Parent Questionnaire

MEDICATIONS □ My child does not take any medications

Name of medicine: Reasons for taking: How long? Prescribed by:

____

____

Allergies to medicine/food/insect stings or bites): □ No □ Yes (Please list):

□ Medications: ____

□ Food allergies (peanuts, seafood, etc.): ____________________________________

□ Insect stings/bites (bee, etc.): ____

□ Other (please explain): ____

Please check below if your child has any of the following medical problems:

□ Asthma	□ High Blood Pressure	□ Headaches	□ Diabetes	□ Chicken Pox (Age: ____)
□ Eating Disorder	□ Seizures/Epilepsy	□ Depression	□ Anxiety	□ Bladder or kidney infection
□ Heart Problems	□ Hay Fever/Allergies	□ Pneumonia	□ ADD/ADHD/Learning disability	
□ Heat Illness	□ Anemia	□ Hernia	□ Sleep problems	□ Sickle cell anemia/trait
□ Mono	□ Scoliosis	□ Vision or hearing problem (circle one: Eyeglasses/Contacts or Hearing Device)		

□ Other: ______________________________

□ Skin problems (circle each): rash eczema blisters itch acne infection warts scabies fungal

Has your adolescent ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type of surgery? □ No □ Yes (please explain): Age ____________ Problem/Type of surgery ______________________________

Tuberculosis (TB) exposure screening:

Was your adolescent born outside the US? □ Yes □ No

Has your adolescent traveled outside the US? □ Yes □ No

Has your adolescent been exposed to anyone with TB or ever had a positive TB test? □ Yes □ No

Does your adolescent spend time with anyone who has been in jail/prison or a shelter? □ Yes □ No

Does your adolescent spend time anyone who uses illegal drugs or has HIV? □ Yes □ No

Was anyone living in your household now born outside the US or have traveled outside the US? □ Yes □ No

1. Do you or any of your family members have any health concerns you would like to discuss with our SBHC staff?	□ Yes	□ No
2. Do you have any questions or concerns about your child or family's diet or nutrition?	□ Yes	□ No
3. Are you concerned about your income meeting the basic needs of your family?	□ Yes	□ No
• Do you need additional food for your family?	□ Yes	□ No
• Do you need additional clothing for your family?	□ Yes	□ No
• Do you need help paying bills for heat and water?	□ Yes	□ No
• Do you need assistance with transportation to medical or school appointments?	□ Yes	□ No
• Are you concerned about housing for your family?	□ Yes	□ No

Care Coordination & Counseling Services

I consent for my child to receive care coordination services on an as-needed basis which will be provided at Wyandotte high school through the Bull Doc clinic. The goal is to help students get access to services in the schools in order to reduce or eliminate the barriers.

Care Coordination services that may be provided include referring students or their families to other agencies in the community. All services are provided during the school day and are <u>free of charge</u>.

I understand that my child may receive counseling services through the Bull Doc clinic, in case of an emergency. I understand that all students can receive a screening for counseling concerns when they come to the clinic. If my child shows or exhibits any signs for issues such as self-esteem, anxiety, depression or trauma, I understand that he/she will receive an evaluation by a health care professional to clarify. I further understand that the clinician will attempt to notify me that counseling services have been recommended and will discuss a treatment plan and/or the limits of confidentiality if treatment is recommended. I understand that my child may receive counseling services through the Bull Doc clinic. I understand that my child may elect to receive counseling using the secure telemedicine service of KU Medical Center (my child would talk with the clinician/therapist live on the computer screen), or they may receive services from the therapist at the school. I understand that my child's mental health services may be provided by a psychology intern under the supervision of a licensed psychologist, and that this information, including the name of the therapist and supervisor, as well as their contact information, will be provided to me . I understand that information about my child will be treated confidentially and professionally. This consent is <u>good for one year after signing</u> and may be revoked at any time.

I give my permission for my child ________________________________ to receive any of the above services.

I further understand that information about my child's screening test results and subsequent treatment may be anonymously combined with that of all children screened for the purpose of program evaluation. I further understand and direct that in no case will any personally identifying information about my child or their results or participation in this program be revealed in such evaluations.

_____ Yes, I agree

_____No, I do not agree

Parent or Guardian

Nam e: ____

Signature: ____ Date Signed: __ __ /__ __ /__ __ __ __

DOB: __ __ /__ __ /__ __ __ __