STUDENT INFORMATION

Student's Name (Last, First, Middle Initial):

Gender:

Birth Date:

Age:

Social Security #:

Address:

City:

Zip:

Primary Phone:

Parent's Email:

Race:

Other

Ethnicity:

Unknown

Mother/Guardian:

Phone:

Father/Guardian:

Phone:

Who does the child live with most of the time?

In case of emergency, please tell us a local friend or relative (not living in the same address) whom we may contact.

Name:

Relationship:

Phone:

Insurance Information

☐ **Commercial/Private**

Insurance Company Name:

Subscriber Name (First, Middle, Last):

Subscriber Address:

Subscriber Phone:

Preferred Language:

Patient Relation to Subscriber:

Employer Name:

Subscriber Date of Birth:

Last 4 Digits of Social Security Number:

Subscriber’s Policy Number:

Effective Date:

Group Name:

Group Number:

☐ **Medicaid**

Member ID Number:

☐ **No Health Insurance**

If your child does not have health insurance, would you like someone from Hancock Regional Health to reach out to you regarding coverage options and financial assistance programs available?

No

Health Questionnaire

Does your child have any known allergies? No

List all known allergens:

Does your child have any physical disabilities? If yes, please explain: No

Is your child currently being treated for any health or mental health problems? If yes, explain and list who is providing the treatment: No

Does your child receive daily medications? No

Please list all medications, the dosage, and when given:

Primary Care Doctor:

Office Address:

Telephone Number:

If we need to call in a prescription, which pharmacy would you like us to call?

Does the student, or anyone in the home:

	Yes	No	Name of Person	Relationship to Student
Smoke				
Drink				
Use Drugs				
Chew Tobacco				

Child's Medical History

Please check if our child has or has had any of the diseases or conditions listed below.

- ☐ Allergies
- ☐ Anemia
- ☐ Kidney/urinary tract problems
- ☐ Problems walking
- ☐ Asthma/respiratory problems
- ☐ Shortness of breath during exercise
- ☐ Stomach ulcers
- ☐ Skin rashes
- ☐ Abdominal pain
- ☐ Constipation/diarrhea
- ☐ Serious digestive issues
- ☐ Ear problems
- ☐ Ear infections
- ☐ Hearing aid(s)
- ☐ Eye problems
- ☐ Wears glasses
- ☐ Muscular-skeletal problems
- ☐ Rheumatic fever
- ☐ Physical/sexual abuse
- ☐ Hemophilia
- ☐ Fainting spells/ knocked out
- ☐ Frequent sore throat
- ☐ Headaches
- ☐ Frequent colds
- ☐ Lung problems
- ☐ Meningitis
- ☐ Menstruation began at age _____
- ☐ Menstrual problems
- ☐ Premature Birth

_____

- ☐ Obese/Overweight
- ☐ Underweight
- ☐ Serious acne
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hepatitis

Major injuries

Broken bones

Behavior History

- ☐ Nightmares
- ☐ Bedwetting
- ☐ Eating problems
- ☐ Thumb sucking
- ☐ Discipline problems
- ☐ Overactive/hyperactive
- ☐ Shy
- ☐ Sleeping problems
- ☐ Slow development
- ☐ Learning disability
- ☐ Smoker
- ☐ Alcohol
- ☐ Inhalant abuse
- ☐ Other drugs
- ☐ Depression
- ☐ Other behavioral problems

Explain any conditions, behavior or medical history checked:

COMMENT: The response to this question and the information provided here may also trigger the school's child find obligation and/or be sufficient to put the school on notice that the student may have a disability protected by Article 7 or Section 504.

CONSENT

Child's Name:

Date of Birth:

This consent is for the treatment of your child by Hancock Regional Health (HRH), a licensed healthcare provider that provides standard clinical health care treatment and telemedicine. Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance and in this case, provided through a telehealth clinic. This means that there will be two-way video conferencing between the healthcare provider at HRH and your child with the school nurse or assigned school official. Any exam that is requested by the healthcare provider will be accomplished by state of the art technology, allowing high-resolution visualization of the ears, throat, and skin, as well as high fidelity sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school.

Before any student is seen at HRH, a signed consent form must be on file. In addition to the consent on file, an attempt will be made to contact the parent/guardian before each visit in an effort to receive verbal consent for the child to be seen. Please check the appropriate box below regarding verbal consent.

◯ I give permission for my child to be seen at HRH if verbal consent from parent/guardian is not received, e.g., unable to contact parent/guardian by telephone, phone number disconnected, etc.

◯ I DO NOT give permission for my child to be seen at HRH if verbal consent from parent/guardian is not received. I want to speak with the school nurse before my child is seen.

Hancock Regional Health may, depending on the diagnosis, prescribe medication to students seen at the clinic. In the event that the clinic physician prescribes medication, they will make every effort to contact the student's primary care provider (identified on page 4 of this Packet). Such a contact requires the consent of the student's parent or guardian. Please check the appropriate box below regarding contacting your child's primary care provider.

◯ I consent to the Clinic notifying my child's primary care provider (identified on page 4 of this Packet) that the Clinic provider has issued a prescription for my child.

◯ I DO NOT consent to the Clinic notifying my child's primary care provider (identified on page 4 of this Packet) that the Clinic provider has issued a prescription for my child.

I, the undersigned,

- Give permission and consent for my child to have treatment through and by HRH including via telemedicine technology.
- Have received a brochure describing telemedicine and HRH. I understand the information provided including the details and limitations of the form and style in which medical services will be provided.
- Understand that this consent form is valid for as long as the student is enrolled in the school or until I provide the school nurse with written directions otherwise.
- Give permission for HRH, the school nurse, and my child's primary health care provider to speak with and share medical information about my child's health on an as needed basis, with the understanding that this information will be treated in a confidential way.
- Give permission for HRH to receive information from the school and my child's primary health care provider about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on the school website or at the school nurse office).

Child's Name:

Date of Birth:

As parent/guardian of the above student, I:

- Authorize the release of any information necessary to process insurance claims for payment of benefits to Hancock Physicians Network.
- Authorize Hancock Physicians Network to apply for benefits on my child's behalf for services rendered by him/her or his/her order.
- Authorize that payment from my insurance provider be made directly to Hancock Physician Network (or the party who accepts assignment).
- I understand that I am responsible for all unpaid charges, including all deductibles, copays, and non-covered services. If my account is turned over to an outside collection agency, I will be responsible for my balance plus any legal fees or collection fees involved.
- Have provided details of all insurance policies that cover my child.

The information above and on the preceding pages are true and complete to the best of my knowledge.

Parent/Guardian name printed:

Parent/Guardian Signature:

Date: