PLEASE RETURN THIS TO SCHOOL TOMORROW

Parents:

The SCCSD, in partnership with Delta Health Center, Inc. has opened School-Based Health Clinics (SBHC) to care for district students and employees. The SBHC's are full capacity regular clinics on 7 of the school campuses, staffed by state licensed Family Nurse Practitioners and Licensed Practical Nurses. The purpose of having a SBHC is to allow students, faculty, and staff the convenience of receiving quality health care & treatment while minimizing the disruption of normal daily activities (classroom instruction for students and teachers and work for parents).

Please complete the authorization below and all the attached forms and have your child return them to his/her teacher. **All services are provided for children with Medicaid, Chips, Private Insurance, or those with no insurance coverage. If you have any questions, please call 662-741-8800.** You will not receive a bill or charged a co pay for any of our services provided to students, ***but you may receive an explanation of benefits from your insurance company*** which is **NOT A BILL**

PARENTS, PLEASE FILL THIS OUT IN INK.

Please Print

CHILD'S NAME: ______________________________ **DATE OF BIRTH:** ________

SCHOOL NAME: ____

HOMEROOM TEACHER: ______________________ **GRADE:** _______ **AGE** _____

Parent/Guardian Name ________________________________

Parent/Guardian Date of Birth ___________________________

Address ____

Home Phone _________________________ **Cell** ____________________________

Work Phone: _________________________

Family Physician: ____

Family Dentist: ____

MEDICATIONS: ____

MEDICATION/FOOD ALLERGIES: ____

PAST MEDICAL HISTORY: ____

HEALTH PROBLEMS: ____

INSURANCE TYPE: (Circle One) MEDICAID CHIPS UNINSURED PRIVATE

INSURANCE NAME: ________________________ INSURANCE ID# _________________

MEDICAID ID# ___________________________ MS CHIP ID# ___________________

Consent Form

SCCSD/DHC School Based Health Clinic Consent for Treatment Form

I,____, hereby agree to allow ____________________________, my child, to be treated by the SCCSD/DHC School Based Health Clinic provider. I hereby consent to __________________'s treatment and the charges to my insurance or grant funds based on the SCCSD/DHC School Based Health Clinic agreement. This approval for treatment is based on my legal right to provide such consent due to the fact that I am the (circle the appropriate relationship) Parent Guardian Insured Guarantor Other of the above listed child.

Signature ____________________________________ Date ___________

Printed Name __________________________________

I hereby give permission for the provider/nurse to administer/prescribe medications and/or vaccines as needed at the clinic to my child ____.

Signature____ Date________________

Printed Name____

Furthermore, I, also consent to Delta Health Center submitting billing information to my health insurance for (child's name) ______ ______________________ or will speak with DHC personnel regarding the DHC sliding fee discount program. ***I also understand I, nor my child, will be held responsible for any out-of-pocket fees beyond what will be claimed by DHC via health insurance or grant program.***

Signature ______________________________________ Date _____________________

Printed Name _______________________________

******NOTE***** Parents are permitted and encouraged to schedule and attend appointments with students in the SBHC. Notices will go out when immunizations, physicals, screenings and other mass services are offered.

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"A Healthier Delta; A Healthier Mississippi"
Since 1965

THIS FORM HAS TO BE SIGNED AND TURNED BACK IN TO YOUR CHILD'S TEACHER IN ORDER FOR YOUR CHILD TO BE SEEN.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY AND CONSENT TO USE/DISCLOSE HEALTH INFORMATION

I acknowledge that I have received a copy of Delta Health Center's Notice of Privacy Practices. I understand that as part of my healthcare, DHC originates and maintains health records describing child's health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among many healthcare professionals who contribute to my child's care
- A source of information for applying my child's diagnosis to any bill
- A means by which reimbursement agencies can certify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of the healthcare professionals

I request the following restrictions to the use or disclosure of my child's health information:

____

____

____

I hereby authorize a member of Delta Health Center, Inc. and Sunflower County Consolidated School District to exchange health and education/records.

Child's Name: ________________________________ Date ____________

Signature of Parent/Legal Guardian/Relation ___________________________ Date _______

PLEASE RETURN THIS TO SCHOOL TOMORROW

Patient Data Form

DHC Patient #:
School ID #:

Last Name:____________________ First Name:_____________________ Middle Initial:

Preferred Name:______________________________

Social Security #:___________________________

Address ______________________________

Address ______________________________

County:________________________

City:____________________ State________

Emergency Contact:_________________________

Relationship:______________________________

Contact Information:__________________________

Check All That Apply

Agricultural Worker
or Dependent: ____YES ____NO ____Decline

Homeless: ____YES ____NO ____Decline

Veteran: ____YES ____NO ____Decline

Public Housing: ____YES ____NO ____Decline

Siblings in Sunflower County Consolidated Schools:

____
Name School/Grade Age

____
Name School/Grade Age

____
Name School/Grade Age

____
Name School/Grade Age

How would you characterize your current living arrangement?

__Homeowner __Rent __Doubling Up __Transition Housing

__Homeless/Shelter __ Other

Gender: ____Male ____Female

Home Phone:______________________

Mobile Phone:_____________________

Work Phone:______________________

Contact Preference: ____Mobile Phone
____Home Phone ____Work Phone
____Mail ____Patient Portal

Patient or Guardian Email (below)__None __Decline

____

Usual or Preferred Doctor/Pediatrician/Practitioner

Name_________________________________

Phone_________________________________

City/State______________________________

Patient Marital Status: ____Single ____Married
__Divorced ___Separated ___Widowed ___Partner

Language: ____English ____Other___________
____Need Interpreter ____Decline

Race: ____White ____Black ____Hispanic

____Asian ____Other Pacific Islander ____Decline

Ethnicity: ____Non-Hispanic/Latino ____Hispanic/Latino

What is the patient's assigned sex at birth? __Male __Female
What is the patient's current gender identity? __Male __Female
__Trangender Female (Male to Female)
__Transgender Male (Female to Male)

Do you think of yourself as: __Lesbian/Gay __Straight __Bisexual

__Something Else __Don't Know