Once you have completed this form, please save and email to: SBHC@scpccga.org

SOUTH CENTRAL PRIMARY CARECENTER, Inc.
SCHOOL BASED HEALTH CENTER (SBHC)
Consent for Health Services & Transportation

South Central Primary Care Center, Inc. has established a health program within the Ben Hill County School System. The center will provide medical and mental health services. The services will include diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, routine health physicals, immunizations, counseling, behavioral health, health education/promotion, hearing and vision screenings, lab testing, and referrals to medical specialist when needed. Telehealth services may be utilized to provide care as needed.

The primary focus of the school-Based Health Center is to provide quality, accessible health care to the children of Ben Hill County School System to positively impact the children's health, school attendance, and academic performance.

I hereby request and authorize that:

Print Student's Name: _____ _____
First Name Middle Initial Last Name Birth Date

Receive health care services available from and deemed necessary by the staff of the SBHC and their associated provider agencies. These services may include, but are not limited to, such procedures as evaluation and treatment of acute illness and injuries. Consent is also given for telehealth, referral of care to specialist as needed, and if needed emergency transportation to the hospital when deemed necessary by the SBHC staff.

The school-Based Health Center encourages each student to involve his/her parents or guardians health decisions whenever possible. Consent for services is authorized for the length of time the youth is enrolled in the Ben Hill County School System.

I have read and understand the above information and I give permission for my child to receive care as described above and I consent for my child to be transported/accompanied to and from center service locations by a school designee. I also understand that I may obtain further information regarding the services offered by the SBHC by calling the center directly.

Parent/Guardian Name: _____Relationship: _____

Parent/Guardian Signature: _____Date: _____

Parent/Guardian DOB: _____Email: _____

Mailing Address: _____

Home Phone#: _____Cell Phone#: _____

Emergency Contact Phone #: _____

Emergency Contact Name: _____

Pharmacy Name and City: _____

Insurance Name & Policy #: _____

Ben Hill County School Based Health Center
INFORMED CONSENT AGREEMET

The purpose of the Ben Hill County School Based Health Center is to provide a wide array of health, education and support services to children and their families. In order to ensure that our services meet the community's needs, we routinely collect information and continually assess our effectiveness.

Some of the information collected will include your child's school and program attendance, academic performance and behavior. This information will be collected from the Ben Hill County School System. All of the information collected will be confidential and participants will always remain anonymous in the sharing or reporting of any data.

By signing below, you agree to the following:

1. I give permission for the Ben Hill County School Based Health Center to collect information on my child's attendance, academic achievement (including report cards standardized test scores), participation in educational programs (examples are special education, EIP, etc), and behavior (including discipline referrals and suspensions) from the Ben Hill County School System.

2. I understand that any information that is collected from the Ben Hill County School Based Health Center of Ben Hill County School System will be handled confidentially and will only be released anonymously (without names or other personal information attached).

3. I understand that my child's participation and my participation in the Ben Hill County School Based Health Center initiative or evaluation activity are completely voluntary and we may withdraw at any time.

4. I understand that my child will not be denied access to clinics' services if I choose not to participate.

_____ _____

Student Name Date

_____ _____

Parent Signature Date

If you have any questions regarding this evaluation/study, please contact (229) 468-9166

Insurance Information

Please complete this information below and return the information with your signature to the Ben Hill County School Based Health Center Department

Child's Information

Child's Legal Name: _____ Date: _____

Phone number: _____ Birth Date: _____ SSN: _____

Address: _____

Covered by an insurance plan? Yes ☐ No☐ If Yes, please fill in the appropriate section below.

Medicaid Information

Medicaid ID#: _____ Member ID#: _____

Private Insurance Information

Insured Parent/Legal Guardian: _____

Birth Date of Card Holder: _____ SSN of Card Holder: _____

Address (if different from child): _____

Place of Employment: _____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ ID Number: _____

From (month/year): _____ To (month/year): _____

Parent Signature _____ Date _____

BEN HILL COUNTY SCHOOL BASED HEALTH CENTER STUDENT HEALTH QUESTIONNAIRE

Child's Name: _____ _____ _____
Last **First** **Middle Initial**

Date of Birth: _____ Age: _____ Grade: _____ Race: _____
Month/Date/Year

Today's Date: _____ School Name: _____
Month/Date/Year

The information you provide is **STRICTLY CONFIDENTIAL**. Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.

Family Information

Your Name	How are you related to the above-named child?
Click or tap here to enter text.	Click or tap here to enter text.

1. With whom does your child live? (Check All That Apply)

☐ both natural parents ☐ stepmother ☐ alone
☐ mother ☐ stepfather ☐ brother(s)/ages: _____
☐ father ☐ guardian ☐ sisters(s)/ages: _____
☐ adoptive parents ☐ other (explain) _____

2. Does anyone else take care of your child? ☐ Yes ☐ No
If yes, who? _____

3. Does your child have any health problems? ☐ Yes ☐ No
If yes, what? _____

4. Where do you take your child when he/she is sick and who is your child's doctor?
_____

5. Where do you take your child for dental care? _____

6. Does your child have any allergies to any medications? ☐ Yes ☐ No
If yes, what? _____

7. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? ☐ Yes ☐ No
If yes, what? _____

8. Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, when? _____ Where? _____ Why? _____

9. Do you have any concerns about your child? ☐ Yes ☐ No
If yes, what? _____

10. Are your child's parents: (Please Check Answer) ☐ Married ☐ Separated ☐ Divorced ☐ Non-Married Parents
If divorced, when? _____

11. Do the child's parents work outside the home? ☐ Yes ☐ No
If yes, what type of work do they do? Mother _____ Father _____

Family Medical History

12. Does the child's mother, father, siblings or grandparents have any of the following?

	If yes, who?		**If yes,** who?
High Blood Pressure	☐Yes ☐ No _____	Learning Problems	☐ Yes ☐ No _____
Diabetes	☐ Yes ☐ No _____	Mental Illness	☐Yes ☐No _____
Lung Problems	☐Yes ☐No _____	Nerve Problems	☐Yes ☐ No _____
Asthma	☐Yes ☐No _____	Drinking Problems	☐Yes☐ No _____
Heart Problems	☐Yes ☐ No _____	Drug Problems	☐ Yes ☐No _____
Cancer	☐Yes ☐No _____	Other	_____
Miscarriages	☐Yes ☐ No _____		

Family Health Habits

13. How often does your child use a seatbelt (car seat)? (Please Check Answer)
☐. Never ☐. Rarely ☐. Sometimes ☐. Often ☐. Always

14. Does your child ride a bicycle, skateboard, or roller blade? ☐ Yes ☐ No _____
☐. Never ☐. Rarely ☐. Sometimes ☐. Often ☐. Always

15. Does your child need information about safety (strangers or unknown adults, matches, etc)? ☐ Yes ☐ No _____

16. How many hours of sleep does your child get each night? _____ hours

17. Do you feel that you live in an unsafe place? ☐ Yes ☐ No _____

18. Have there been any major changes in your family such as (Check All That Apply)

☐ moving ☐ death of family member ☐ violence or serious accident
☐ physical, emotional, sexual abuse ☐ loss of job ☐birth ☐other

19. Do you have a gun at home? ☐ Yes ☐ No _____
If yes, is it locked? ☐ Yes ☐ No _____

20. Does anyone in your household smoke? ☐ Yes ☐ No _____

21. Do you currently smoke cigarettes? ☐ Yes ☐ No _____
If yes, how many cigarettes do you smoke per day? _____ cigarettes a day

School History

22. Did/does your child attend preschool? ☐ Yes ☐ No _____

23. Do you have any concerns about your child's school performance? ☐ Yes ☐ No _____
If yes, what? _____

24. Do you have any concerns about your child's relationship with teachers? ☐ Yes ☐ No _____

25. Do you have any concerns about your child's relationship with other students? ☐ Yes ☐ No _____

26. Do you have any concerns about your child's relationships with siblings or other family members? ☐ Yes ☐ No _____

27. If over 4 years old, does your child have a best friend? ☐ Yes ☐ No _____

28. Does your child participate in sports/exercise or have hobbies, special interest or talents? ☐ Yes ☐ No _____

If yes, what _____ How often? _____ How long? _____

NAME _____ **BIRTHDATE** _____ **TEACHER** _____

Allergies	☐Yes ☐No
Allergic to drugs	☐Yes ☐No
Anemia	☐Yes ☐No
Asthma	☐Yes ☐No
Other Respiratory Problems	☐Yes ☐No
Stomach Ulcers	☐Yes ☐No
Abdominal Pain	☐Yes ☐No
Constipation/Diarrhea	☐Yes ☐No
Serious Digestive Problems	☐Yes ☐No
Chicken Pox Age ___	☐Yes ☐No
Ear Problem	☐Yes ☐No
Ear Infections	☐Yes ☐No
Hearing Aid	☐Yes ☐No
Eye Problem	☐Yes ☐No
Wears Glasses	☐Yes ☐No
Physical/Sexual Abuse	☐Yes ☐No
Fainting Spells/Knocked Out	☐Yes ☐No
Frequent Sore Throat	☐Yes ☐No
Headaches	☐Yes ☐No
Heart Murmur	☐Yes ☐No
Heart Problems	☐Yes ☐No
High Blood Pressure	☐Yes ☐No
Thyroid Problems	☐Yes ☐No
Diabetes	☐Yes ☐No
Hepatitis	☐Yes ☐No
Injuries (major)	☐Yes ☐No
Musculo-Skeletal Problems	☐Yes ☐No
Broken bones	☐Yes ☐No
Problems Walking	☐Yes ☐No
Kidney/Urinary Tract Problems	☐Yes ☐No
Frequent Colds	☐Yes ☐No
Kidney/Urinary Tract Problems	☐Yes ☐No
Frequent Colds	☐Yes ☐No
Lung Problems	☐Yes ☐No
Menstruation Stated Age Click or tap here to enter text.	☐Yes ☐No
Menstrual Problems	☐Yes ☐No
Premature Birth Weight Click or tap here to enter text.	☐Yes ☐No
Obese	☐Yes ☐No
Skin Rashes	☐Yes ☐No
Serious Acne	☐Yes ☐No
Sickle Cell Disease	☐Yes ☐No
Sickle Cell Trait	☐Yes ☐No
Other Blood Disorders	☐Yes ☐No
Seizures/Epilepsy	☐Yes ☐No
Speech Problem	☐Yes ☐No
Tuberculosis	☐Yes ☐No
Cancer	☐Yes ☐No
Other_____	

BEHAVIOR STUDY

Eating Problems	☐Yes ☐No
Thumb Sucking	☐Yes ☐No

BEHAVIOR STUDY (Cont'd)

Nightmares	☐Yes ☐No
Bedwetting	☐Yes ☐No
Discipline Problems	☐Yes ☐No
Overactive/Hyperactive	☐Yes ☐No
Shy	☐Yes ☐No
Sleeping Problems	☐Yes ☐No
Slow Development	☐Yes ☐No
Learning Disability	☐Yes ☐No
Smoker	☐Yes ☐No
Alcohol	☐Yes ☐No
Inhalants	☐Yes ☐No
Other Drugs _____	☐Yes ☐No
Depression	☐Yes ☐No
Other Behavior Problems	☐Yes ☐No
Other Mental Problems	☐Yes ☐No
Other _____	☐Yes ☐No

Explain any behavior or mental problems notes _____

_____

_____

PLEASE LIST ANY PRESENT CONCERNS: _____

_____

***Explain any illnesses marked yes: _____

_____

_____

DENTAL

Dental Problems	☐Yes ☐No
Meningitis	☐Yes ☐No
AIDS/HIV	
Rheumatic Fever	☐Yes ☐No
Hemophilia	☐Yes ☐No
Underweight	☐Yes ☐No

When was your child's last dental visit?

_____

How often are your child's teeth brushed?
☐Occasionally ☐Once a Day ☐Twice ☐Other

Has your child had a toothache recently?	☐Yes ☐No
Has your child had any injury to teeth or jaws?	☐Yes ☐No
Does your child have a finger or thumb sucking habit?	☐Yes ☐No

Generally speaking, what has been your child's experience with a dentist? ☐Good ☐Bad ☐Very Bad
☐No experience (the child's first visit)

THANK YOU!

SOUTH CENTRAL PRIMARY CARE CENTER, INC

SCHOOL BASED HEALTH CENTER

Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee, to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: _____ Date of Birth: _____
Last Name First Name MI (MM/DD/YYYY)

Parent/Guardian: _____
Last Name First Name MI

INELIGIBLE FOR STATE SUPPLIED VACCINE (check if applicable)

The child has insurance that pays for immunizations. (Full insured/Private Pay) ☐

ELIGIBLE FOR STATE SUPPLIED VACCINE
This child qualifies for vaccination with state-supplied vaccine because (check only one)

The child is enrolled in Medicaid, a Medicaid Care Management Plan, or PeachCare for Kids ☐
The child is American Indian or Alaskan Native ☐
The child does not have health insurance (Not insured) ☐
The child has health insurance that does not pay for vaccines (Under-insured) ☐

Note to providers: A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age and younger who receive immunizations with vaccines supplied by state programs. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Immunization Verbal (Telephone) Consent

Patient Name: _____ Patient Age: _____

Chart#: _____ Today's Date: _____ ☐ State provided Vaccine(s) ☐ Private Stock Vaccine(s)

A copy of the appropriate Vaccine Information Statement (VIS) has been provided. I have read, or have had explained, the information about the diseases and the vaccines listed below. There was an opportunity to ask questions and any questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited below and give permission that the vaccine(s)listed below is given to the person named above (for whom I am authorized to make this request).

VACCINE(S) ADMINISTERED	LOT NUMBER	EXPIRATION DATE

_____ _____
1st Witness to Consent Consent Given By & Relationship to Patient

_____ _____
2nd Witness to Consent Vaccine Administrator Signature & Title