

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 Irwin 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 Irwin 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 Irwin 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 #: _____

**Irwin County School Based Health Center
INFORMED CONSENT AGREEMENT**

The purpose of the Irwin 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 Irwin 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 Irwin 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 Irwin County School System.
2. I understand that any information that is collected from the Irwin County School Based Health Center of Irwin 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 Irwin 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 Irwin
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 _____

**IRWIN 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
Click or tap here to enter text.

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

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

- | | | |
|---|--|---|
| <input type="checkbox"/> both natural parents | <input type="checkbox"/> stepmother | <input type="checkbox"/> alone |
| <input type="checkbox"/> mother | <input type="checkbox"/> stepfather | <input type="checkbox"/> brother(s)/ages: _____ |
| <input type="checkbox"/> father | <input type="checkbox"/> guardian | <input type="checkbox"/> sisters(s)/ages: _____ |
| <input type="checkbox"/> adoptive parents | <input type="checkbox"/> 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?

Never

Rarely

Sometimes

Often

Always

Yes No _____

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 Yes No
or tap here to enter text.
- Menstrual Problems Yes No
- Premature Birth Weight Click Yes No
or tap here to enter text.
- 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 (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 Yes No
- 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)

BEHAVIOR STUDY

- Eating Problems Yes No
- Thumb Sucking Yes No

THANK YOU!

