STUDENT/PATIENT'S NAME:_____ DATE OF BIRTH_____

PLEASE REVIEW THE FOLLOWING INFORMATION

Welcome to the School Based Health Center (SBHC) The Leopard Nation Wellness station. The School Based Health Center makes medical and mental health services available to all students when needed. If your child/adolescent becomes sick or injured or needs a check-up, sports physical, immunizations, or counseling services they can have it done in the School Based Health Center. If you have any questions or need help with the application, please call South Central Medical Center at 405-756-1414.

Patient Rights and Responsibilities

- Respectful and equal treatment, care and accommodations are available regardless of race, age, ethnicity, creed, sex, or sexual orientation.
- To have health care assessment and plan of care and participate in your health care plan.
- To talk with your health care provider openly and privately.
- It is the patient's/guardian's responsibility to carry out the recommended treatment plan.
- Allow 30 days for the completion of insurance and disability forms.
- Notify the SBHC if you have received treatment in an Emergency Room or Hospital.
- *After hours*, in case of an emergency please call 911 or go to the nearest Emergency Room. If you have an urgent issue and would like to speak with the provider, please call 405-756-1414.

Regarding PAYMENT FOR SERVICES

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate ***discounted fee.*** However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income and size will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on South Central Medical Center's Sliding Fee Scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid.

Regarding the SHARING OF HEALTH INFORMATION

- The School Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the SBHC to your child's regular doctor/clinic when requested.
- The School Based Health Center and/or South Central Medical Center will share information with each other as needed.
- Dates of service regarding completed medical and immunization care may be shared with the school if you agree and sign the authorization form provided with the consent.

I have the right to review or receive a copy of the Notice of Privacy Practice. I acknowledge that I have been offered a copy of the Notice of Privacy Practice and authorizations for information regarding my child.
I have received or reviewed a copy:

➡ **Signature & Date:** _____

I authorize the SBHC to call my home or cell phone number and leave a message with an individual listed in this paperwork on their voicemail pertaining to my child's medical care, including lab results.

☐ YES ☐ NO

I authorize the SBHC to share information such as immunization data, school notes, and physicals with the Lindsay Public School on an as needed basis. ☐ YES ☐ NO

Authorization Consent:

➡ **Signature and Date:** _____

School Based Health Center
Enrollment Packet

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: _____

PREFERRED NAME**:** _____

Date of Birth: _____

Gender (CIRCLE): Male Female Non-Binary

Trans (CIRCLE): MTF FTM

RACE (CIRCLE): Caucasian Black/African American Asian American Indian or Alaskan Native Native Hawiian or Pacific Islander

Other Race Specify _____

ETHNICITY (CIRCLE): Hispanic/Latino Non-Hispanic Not Reported

Medical Services

MEDICAL HEALTH SERVICES:

☐ **YES**, I consent for my child to receive MEDICAL CARE including routine well child care, appropriate immunizations **AS CONSENTED FOR** by parent/guardian, treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: Well child care can include urine and blood tests when indicated). My child may be **TRANSPORTED/ACCOMPANIED** to and from medical services by a school designee or a South Central Medical Center employee. I, the parent or guardian of the above named student, release Lindsay Public School System, its employees, representatives and/or Board, SCMRC, its employees, representatives and/or Board from any personal injury or damage resulting from the transportation of my student to and from the health center.
***This does not change your child's Primary Care Provider (PCP) to SCMC unless you choose to do so.**

☐ **NO**, I do not wish for my child to receive MEDICAL CARE at the school based health Center (SBHC)

Mental Health Services

MENTAL HEALTH SERVICES:

☐ **YES**, I consent for my child to be allowed to receive **MENTAL HEALTH SERVICES** at the SBHC. This includes screening, assessment and brief intervention**; however, all treatment must have separate consent signed by the parent or guardian prior to ongoing treatment.** My child may be TRANSPORTED/ACCOMPANIED to and from mental health services by a school designee or a South Central Medical Center employee. I, the parent or guardian of the above named student, release Lindsay Public School System, its employees, representatives and/ or Board, SCMRC, its employees, representatives and/or Board from any personal injury or damage resulting from the transportation of my student to and from the health center.

***PLEASE NOTE: Any student regardless of consent status in a crisis situation with threats of harm to themselves or others will have immediate intervention by the SBHC's Mental Health professional while the parents are being contacted to mitigate the risk of harm to themselves or others.**

☐ **NO,** I do not wish for my child to receive MENTAL HEALTH SERVICES at the School Based Health Center.

I give consent for my child to obtain services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in the Program Description form (attached). **Consent remains in effect until terminated in writing by Parent/Guardian, or until child graduates or turns 18.**

_____

Parent/ Guardian Signature (or if patient over 18) Parent/Guardian Name PRINT (or patient if over 18) Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, give my permission to release any health information to the following:

Name/Relationship	Phone Number
Name/Relationship	Phone Number

I understand that:

1. **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3. I may revoke this authorization at any time by notifying SCMC/SBHC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4. SCMC/SBHC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to the authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

_____ _____

Signature of Patient or Legal Representative (if applicable) Date

_____ _____

Printed Name of Patient or Legal Representative (if applicable) Relationship to Patient (if applicable)

Leopard Nation Wellness station

Est. 2019

Student and Family Health History

Student Name: _____ Student DOB: _____ Student SSN:_____

Parent/Guardian Name: _____ Parent/Guardian DOB:_____

Relationship to Child: _____ Parent/Guardian SSN:_____

Medical Card/Insurance ID: _____ Group ID:_____

Insurance Carrier: _____

Phone (Best)_____ Phone #2 _____ Phone #3 _____

EMAIL _____

_____

ADDRESS CITY STATE ZIP CODE

I WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS BY (Please circle): TEXT MESSAGE or PHONE CALL

Any history of the following problems? (Please circle **Y** for Yes and **N** for No)

History for Student and Family	Student	Family
Allergies: Seasonal/ Hay Fever	Y N	Y N
Life Threatening Allergy to: _____	Y N	
EpiPen Prescribed	Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Disorders	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems_____	Y N	Y N
Blood Pressure Issues (High/ Low)	Y N	Y N
Developmental Problems_____	Y N	Y N
Cancer -Type_____	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	Y N
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History for Student and Family	Student	Family
Emotional/ Psychological Problems	Y N	Y N
Frequent Headaches	Y N	
Head Injury/ Concussion	Y N	
Frequent Stomach Aches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease-Type_____	Y N	Y N
Kidney Disease-Type_____	Y N	Y N
Learning Problems_____	Y N	Y N
Prematurity or Birth Weight Under 5 lbs	Y N	Y N
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothache/ Dental Problems	Y N	Y N
Problems with Vision	Y N	Y N
Wears Glasses/ Contacts	Y N	
Surgery(s):_____	Y N	

Regular **Medical** Dr. or Clinic_____ Phone #_____

Date of last complete yearly physical exam (Well Child Exam): _____

Regular **Dentist**_____ Phone #_____

Date of last routine dental checkup: _____

Regular **Eye** Dr.: _____ Phone #_____

Date of last routine eye exam: _____

Preferred **Pharmacy**: _____ Phone #_____

Please list any **CURRENT** health problems or conditions your child has:_____

_____

Please list any **ALLERGIES** (including food, medications, environmental, seasonal etc.) your child has: _____

_____

Does your child see a **SPECIALIST**? If yes, please list condition and providers name: _____

_____

Please list any **MEDICATIONS** and the dosage (prescribed or over the counter) your child takes AT HOME on a daily basis or on an as needed basis (such as medications for ADHD, allergies, asthma, or headaches): _____

_____

Has your child has any operations, serious injuries, or hospitalizations? NO ☐ YES ☐

Please provide reason and year:_____

Has your child ever been pregnant? NO ☐ YES ☐

Authorization for Administration of Over-the-Counter Medications at School

****This form expires at the end of the current school Year****

2023-2024

School Year

_____ _____

Student's Name Date of Birth

_____ _____ _____

School (Elementary/Middle/High) Grade Teacher/Homeroom

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after school activities.

My student prefers: ☐Liquid/Chewable tablets ☐ Pills

Over-the-Counter Medication	YES	NO
Acetaminophen (Tylenol) for headache, toothache or minor pain	YES	NO
Ibuprofen (Motrin) headache, toothache, minor pain, menstrual cramps	YES	NO
Hydrocortisone (Anti-itch) cream or lotion for rashes, bug bites or stings	YES	NO
Calcium carbonate (Tums) for heartburn or upset stomach	YES	NO
Cetirizine (Zyrtec) for seasonal allergies	YES	NO
Diphenhydramine HCl (Benadryl) for itching or minor allergic reactions	YES	NO
Dextromethorphan (Delsym) for minor cough	YES	NO

Is the student allergic to any medications? ☐ NO ☐ YES, allergic to:_____

Severe reactions that should be reported to provider:_____

I give permission to the School Based Heath Center provider, nurse, medical assistant, or designee to give my child the above mentioned medications for comfort measures. I further agree to indemnify or hold harmless South Central Medical Center and/or the School Based Health Center and its agents from all claims as a result of any and all acts performed under this authority. I will inform the School Based Health Center if there are any changes to this information.

_____ _____

Signature of Parent/Guardian Date

_____

Please Print Name of Parent/Guardian

How can we reach you during school hours?

_____ _____

(1) Emergency Contact Name (2) Emergency Contact Name

_____ _____

Cell Phone Cell Phone

_____ _____

Work Phone Work Phone

Leopard Nation Wellness Station
707 W Comanche
Lindsay, OK 73052
Phone: 405-756-1414 Fax: 405-756-1162

Authorization For Release of Confidential Information

I hereby authorize the release of confidential information for:

Patient Name: _____Date of Birth: _____

Social Security #: _____Daytime phone #: _____

Information Release To:	**From:**
LNWS	_____
707 W Comanche	_____
Lindsay, OK 73052	_____

Please Release the Following:

___History/Physical Exam/Well Child Exam

___Immunizations

Purpose or Need For Disclosure:

___Continued Patient Care

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extend that action has been taken in reliance on it. This consent will expire one full school year after the date of my signature unless otherwise specified.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Wellness Station Staff and Title/Credentials Date