

NEPA *Community Health Care*

providing exceptional care to all those who seek it



NEPA COMMUNITY HEALTH CARE SCHOOL-BASED HEALTH CENTER

School-based health centers are exactly what the name implies: the center of health in the schools where they are based.

Students and their families rely on school-based health centers to meet their needs for a full range of age-appropriate health care services, typically including:

- Primary medical care
- Mental/ behavioral health care
- Health education and promotion
- Substance abuse counseling
- Case management
- Nutrition education

Students can be treated for acute illnesses, such as flu, and chronic conditions, including asthma and diabetes. They can also be screened for dental, vision, and hearing problems. With an emphasis on prevention, early intervention, and risk reduction, school-based health centers counsel students on healthy habits and how to prevent injury, violence and other threats.

School-based health centers often are operated as a partnership between the school and a community health organization, such as a community health center. The specific services provided by school-based health centers vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers.

Parents may call the school nurse's office or our NEPA office to schedule an appointment for their child to be seen at school. The nurse's office will coordinate the appointment with your child's schedule. You may join your child at the appointment if you wish.

Please complete the following forms and return them to school so that we can better serve your family.

Elk Lake School District: 570-278-1106

NEPA Community Health Care: 570-278-7500

Susquehanna Health Center

155 Erie Blvd
Susquehanna, PA 18847
570-853-3577 (p)
570-853-3587 (f)

Hallstead Health Center

25066 State Route 11
Hallstead, PA 18822
570-879-5249 (p)
570-879-2418 (f)

Montrose Health Center

498 South Main St, Suite D
Montrose, PA 18801
570-278-7500 (p)
570-278-7501 (f)

Administration

191 Erie Blvd, Suite C
Susquehanna, PA 18847
570-853-0913 (p)
570-853-0910 (f)

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INSURANCE INFORMATION

DATE: _____

PATIENT'S INFORMATION

Last Name: _____ First: _____ Middle: _____

Date of Birth: ____/____/____

INSURANCE COVERAGE (PLEASE ATTACH A COPY OF BOTH SIDES OF THE CARD)

Name of Insurance Company: _____ Effective date: _____

Company/ Claim Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Policy/ ID/ Patient Number: _____ Group Number: _____

Subscriber Name (parent/ guardian who provides insurance): _____

Subscriber date of birth: _____ Subscriber SSN: _____

Relationship to student: _____

Is the student covered under more than one policy? Please give us information for all insurance coverage, and let us know which one is first (primary).

No insurance coverage? Please contact our office for information regarding sliding fee.

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SCHOOL-BASED HEALTH CENTER CONSENT TO TREAT

Student Name: _____ Date of Birth: _____

I give permission for the NEPA Community Health Care School-Based Health Center to provide medical care to the student named above.

I understand the following types of services are offered through the School-based Health Center:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury
- Treatment of minor injuries
- Vision, dental, hearing and blood pressure screenings
- Age appropriate reproductive health
- Point of care testing
- Immunizations
- Health education, counseling, and wellness promotion
- Nutrition education and weight management
- Prescription medications
- Mental health services
- Referral for health care services not provided by clinics.

School-Based Health Center (SBHC) program clinical staff share appropriate medical information with Susquehanna Community School District School Health Services nursing personnel in order to support coordination of care for students with special medical needs.

I have read the above information and have had the opportunity to have any of my questions answered.

I understand that I may revoke my consent at any time.

Parent/ Guardian Signature

Date

Best Phone Number to be reached at

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SCHOOL-BASED HEALTH CENTER CONFIDENTIALITY

Student Name: _____ Date of Birth: _____

Your privacy and safety are important to us. In general, adolescents have a right to privacy regarding some health information. If there is a safety concern, privacy cannot be maintained when you are less than 18 years of age or when we are required to report by law.

Having your parent or guardian included in your healthcare is important. We will work with you to involve them as needed while still protecting your privacy.

- Mental health (counseling) which included drug and alcohol services may initially be provided to a person 14 years or older without parent or guardian consent,
- Family planning (birth control) and sexually transmitted disease services may be provided to a person 14 years or older without parent or guardian consent.

There are certain instances that are reportable such as:

- You tell us that you plan to cause serious harm to yourself or someone else.
- You are doing things that could cause serious harm or death to you or someone else.
- You tell us that you are being abused (physically, sexually or emotionally).
- You tell us you have been abused in the past (physically, sexually or emotionally).
- You tell us that you are having sex with someone who is three or more years older than you.
- You have a life threatening health problem.

You have the right to ask about treatment planned for you and to refuse that treatment. You have the right to a chaperone during an examination. (A chaperone is someone who watches the examiner during the examination).

Student Signature

Date

Parent Signature

Date

Last Name: _____ First: _____ Middle initial: _____

Birth Date: _____ Preferred Name: _____

Social Security Number (SSN): _____ Home Phone: _____

Student's Cell Phone: _____ **Can we contact you at home?** Yes No

Address: _____ APT#: _____ City/State: _____ Zip: _____

What school do you attend? _____ Grade: _____

Sex at birth: M F **Gender identity:** M F Transgender Gender questioning
 Unknown/other _____

Ethnicity: Hispanic Non-Hispanic Unknown Refused

Race (check all that apply): Alaskan Native American Indian Asian Black
 Native Hawaiian Pacific Islander White Unknown Refused

Homeless Status: Not homeless Homeless At risk of homelessness

Do you need an interpreter? Yes No If yes, language: _____

Are you a U.S. citizen? Yes No Date of entry to U.S. (if born outside of U.S.) _____

Country of origin: _____

Where do you usually go for health care? _____ Doctor: _____

Where do you usually go for dental care? _____ Dentist: _____

Household Information

How many people live in your house? _____ Family income a year (approximate): \$ _____

Parent/guardian (first & last name): _____ Relationship: _____

Work#: _____ Cell#: _____

Parent/guardian (first & last name): _____ Relationship: _____

Work#: _____ Cell#: _____

Do you live with your: Mother(s) Father(s) Foster Parent(s) Other: _____

List other family members in the house:

Last Name	First Name	Sex	Relationship to Client
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

Insurance Information

Do you have insurance coverage Yes No

Please complete the attached Insurance Information form

Responsible Party (name): _____ Mother Father Caseworker

Case Manager - Caseworker/Manager phone #: _____ Other _____

Parent/Guardian: Date of birth _____ Social Security Number _____

Emergency Contact (Required)

Who is a responsible adult that we can notify in case of emergency: _____

Relationship: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____

HISTORY FORM

Name: _____ Date of Birth: _____

History of:	YES	NO	YES	NO	YES	NO		
No Significant History			PDD/ASD			Otitis Media		
Abuse/ Neglect			Developmental Disorders			Pneumonia		
Allergic Rhinitis			Diabetes			Preterm Infant		
Anemia			Drug Related Disorders			Scarlet Fever		
Asthma			Eczematoid Dermatitis			Seizure Disorder		
Mild Intermittent			Enuresis			Sinusitis		
Mild Persistent			Eyesight Problems			Special Education		
Moderate Persistent			Febrile Convulsion			Speech Difficulties		
Severe Persistent			Fracture			Tonsillitis		
ADD/ ADHD			GERD			Tuberculosis		
Blood Disorders			Headache			Upper Respiratory Infection		
Cancer			Hearing Loss			Urinary Tract Infection		
Cerebral Palsy			Immunologic Disorders			Vesicoureteral Reflux		
Chickenpox			Jaundice					
Concussion			Measles					
Congenital Heart Disease			Mental Illness					
Congenital Malformations			Migraine					
Constipation			Mononucleosis					
Mental Retardation			Mumps					

Hospitalization History:	YES	NO	Living Arrangements:	YES	NO	YES	NO	
Previous Hospitalizations			Living with Parents			Exposed to cigarette smoke		
Fever			# of Sisters			#of Family Members in Home		
GI Problem			# of Brothers			Has Heat Source		
Pulmonary Problem			Step Family			Has City Water		
Prior Surgery			Relatives (Not parents)			Has Well Water		
Ear Tubes			Significant Other			Guns in Home		
Tonsillectomy			Roommate			Pets or other Animals		
Adenoidectomy			Foster Home			Day Care		
Appendectomy			Homeless Shelter			Currently in School		
Gasrostomy			Poverty Conditions			Public School		
Inguinal Hernia Repair			Awaiting DSS			Pivate School		
Nissen Fundopication			Legal Guardian			Home School		
Orchiopexy						Grade:		
Umbilical Hernia Repair						Having Difficulty		
Ureteroplasty						Excelling		
Other Surgery:								

Activities / Exercise:	YES	NO	Sports:	YES	NO	YES	NO	
Tobacco Use			Baseball			Bicycling		
Alcohol			Basketball			Fishing		
Drug Use			Cheerleading			Hiking		
Sexually Active			Football			Hunting		
Condom Use			Golf			Motorcycling		
Homosexual Activity			Gymnastics			Running		
			Lacrosse			Skateboarding		
			Soccer			Skiing		
			Softball			Surfing		
			Swimming			Walking		
			Tennis			Water Skiing		
			Track and Field					
			Volleyball					

Family History:	Mom	Dad	MGM	MGF	PGM	PGF	Brother	Sister	Other
Alcoholism									
Asthma									
Blood Disorders									
Cancer									
Cong. Heart Disease									
CAD									
Crohn's Colitis									
Diabetes									
Drug use									
Seizure Disorder									
Hyperlipidemia									
Rheumatic Disease									
Kidney Disease									
Migraine									
Thyroid Disorders									
Tuberculosis									
Stroke Syndrome									
Hypertension									
Sickle Cell									
Birth Defects									
Cong. Abnormality									
Mental Illness									
Mental Retardation									
Tourette's Syndrome									
Ric Disorder									
ADHD									
Learning									
Dyslexia									
Autistic Disorder									
Depression									
Bipolar Disorder									
Speech									
Schizophrenia									

Mother's Current Age: _____

Mother deceased at age: _____

Father's Current Age: _____

Father deceased at age: _____

Current Medications:	Dose:	Times Per Day:

Allergies: