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.

Susquehanna Community School District: 570-853-4921

NEPA Community Health Care: 570-853-3577

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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

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CLIENT DATA SHEET
School Based Health Center

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
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ 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: ________________

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HISTORY FORM

Name:______________________________ **Date of Birth:**______________

History of:

History of:	YES	NO
No Significant History		
Abuse/ Neglect		
Allergic Rhinitis		
Anemia		
Asthma		
Mild Intermittent		
Mild Persistent		
Moderate Persistent		
Severe Persistent		
ADD/ ADHD		
Blood Disorders		
Cancer		
Cerebral Palsy		
Chickenpox		
Concussion		
Congenital Heart Disease		
Congenital Malformations		
Constipation		
Mental Retardation		

	YES	NO
PDD/ASD		
Developmental Disorders		
Diabetes		
Drug Related Disorders		
Eczematoid Dermatitis		
Enuresis		
Eyesight Problems		
Febrile Convulsion		
Fracture		
GERD		
Headache		
Hearing Loss		
Immunologic Disorders		
Jaundice		
Measles		
Mental Illness		
Migraine		
Mononucleosis		
Mumps		

	YES	NO
Otitis Media		
Pneumonia		
Preterm Infant		
Scarlet Fever		
Seizure Disorder		
Sinusitis		
Special Education		
Speech Difficulties		
Tonsillitis		
Tuberculosis		
Upper Respiratory Infection		
Urinary Tract Infection		
Vesicoureteral Reflux		

Hospitalization History:

Hospitalization History:	YES	NO
Previous Hospitalizations		
Fever		
GI Problem		
Pulmonary Problem		
Prior Surgery		
Ear Tubes		
Tonsillectomy		
Adenoidectomy		
Appendectomy		
Gasrostomy		
Inguinal Hernia Repair		
Nissen Fundopication		
Orchiopexy		
Umbilical Hernia Repair		
Ureteroplasty		
Other Surgery:		

Living Arrangements:

Living Arrangements:	YES	NO
Living with Parents		
# of Sisters		
# of Brothers		
Step Family		
Relatives (Not parents)		
Significant Other		
Roommate		
Foster Home		
Homeless Shelter		
Poverty Conditions		
Awaiting DSS		
Legal Guardian		

	YES	NO
Exposed to cigarette smoke		
#of Family Members in Home		
Has Heat Source		
Has City Water		
Has Well Water		
Guns in Home		
Pets or other Animals		
Day Care		
Currently in School		
Public School		
Pivate School		
Home School		
Grade:		
Having Difficulity		
Excelling		

Activities / Exercise:

Activities / Exercise:	YES	NO
Tobacco Use		
Alcohol		
Drug Use		
Sexually Active		
Condom Use		
Homosexual Activity		

Sports:

Sports:	YES	NO
Baseball		
Basketball		
Cheerleading		
Football		
Golf		
Gymnastics		
Lacrosse		
Soccer		
Softball		
Swimming		
Tennis		
Track and Field		
Volleyball		

	YES	NO
Bicycling		
Fishing		
Hiking		
Hunting		
Motorcycling		
Running		
Skateboarding		
Skiing		
Surfing		
Walking		
Water Skiing		

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: