Southern West Virginia Health System
Lincoln Primary Care Center Inc.

Hello Parent(s),

Lincoln Primary Care Center/Southern West Virginia Health System provides school-based health clinic services at the school your child attends. This is a great benefit to many families because it allows your child to seek medical treatment right at school thus decreasing the amount of time they are away from classroom instruction. The school-based health clinics provide many services including treatment of acute or chronic illnesses, well child exams, sports physicals, immunizations, behavioral health counseling, and health education. If you grant permission for your child to be seen at the school-based health clinic, you will receive a telephone call, or a note sent home each time they are seen at the clinic so you will clearly understand what was discussed with your child.

If you would like to grant permission for your child to use the school-based health clinic you must complete the following attached forms and return them to school as soon as possible. Your child cannot receive services at the clinic unless these forms are completed and are on file at the clinic location.

- School Based Health Center Enrollment and Consent Form
- Notice of Privacy Practices Acknowledgement

The services of the health clinics are provided in partnership with Southern West Virginia Health System dba. Lincoln Primary Care Center, Inc., and the local county Board of Education. These services are funded in part by grants through the West Virginia Division of Primary Care. Please feel free to contact the school-based health clinic to learn more information about the services provided included on the attached flyer.

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School Based Health Center Enrollment and Consent Form

Student Name: _____

Gender: ☐ *Male* ☐ *Female* **Race:** ☐ *White* ☐ *Black* ☐ *Hispanic* ☐ *Other* _____ **Phone:** _____

Address: _____
PO or Street City State Zip

Birthdate: _____ **S.S.N.** _____ **Grade:** ___ **School:** _____

HEALTH INFORMATION

1) Physician's Name: _____ Phone# _____
2) **Does your student**:
Have any medication/drug allergies? If so, what are they allergic to? _____
Have any other allergies we should be aware of (eggs, bees, etc)? _____
Take any medications on a daily basis? _____
Have any chronic illnesses (Asthma, Diabetes, Anemia, etc.) _____
3) Does your child receive Occupational Therapy (OT) services at school? Yes_____ No_____
4) Does your child receive Speech Therapy (ST) services at school? Yes_____ No_____
5) Does Child's insurance cover immunizations? ☐ Yes ☐ No ☐ Uncertain
Immunizations: ***Please provide a copy of your child's most recent immunization record.***

PHARMACY INFORMATION

Which pharmacy would you like to use?
Name: _____ Phone: _____

All medications will be called in to the selected pharmacy, unless otherwise requested.

PARENT(S) OR LEGAL GUARDIAN(S) AND EMERGENCY CONTACT

Parent or Legal Guardian: _____**Relationship:** _____**Phone: Home** _____ **Work/Cell** _____

Parent or Legal Guardian: _____**Relationship:** _____**Phone: Home** _____ **Work/Cell** _____

Emergency Contact : _____**Relationship:** _____**Phone: Home** _____ **Work/Cell** _____

Services Provided by LPCC/SWVHS School Based Health Centers

Treatment of Acute and/or Chronic Illness Physical Exams- Well Child/EPSDTs and Sports Counseling
Immunizations Health Screenings Telehealth Lab Tests (including but not limited to Influenza, Strep, COVID-19, etc)

I would like my child to have a ☐ Comprehensive Physical Exam (EPSDT/Well Child) ☐ Sports Physical ☐ Immunizations

The Health Center will attempt to call a parent/guardian when the child is present at the Health Center to be seen. If we are unable to reach parent/guardian by phone, please indicate how you would like us to notify you that the student has been seen by the Provider.

☐ Send a note home with the student.
☐ Make a phone call to alert me that a note was sent home with a student.
☐ Notify me by the patient portal.
☐ Mail me the follow-up instructions.

I understand routine services such as sports physical exams, treatment of acute illnesses, and provision of over-the-counter medications (i.e. Tylenol) may be provided without prior notification of parents.

MEDICAL INSURANCE INFORMATION: Please check all that apply/or *Provide copy of card*.

☐ **Medicaid**: child's number: _____ (additional information may be required).
***Please check appropriate plan**: ☐Coventry ☐Unicare ☐Mountain Health Trust ☐Molina (straight) Medicaid

*Doctor listed on card: _____Phone: _____

☐ **CHIP** (Children's Health Insurance Program) number: _____

☐ **Primary Medical insurance:**

_____ _____ _____
Insured parent/guardian Insured Date of Birth Insured SSN

_____ _____ _____
Insured Address (if different from child) Phone Number

_____ _____
Insurance company name/address Phone Number

_____ _____
Group Number ID Number

_____ _____
Insured's Employer Phone Number

☐ **Secondary Medical insurance:**

_____ _____ _____
Insured parent/guardian Insured Date of Birth Insured SSN

_____ _____
Insured Address (if different from child) Phone Number

_____ _____
Insurance company name/address Phone Number

_____ _____
Group Number Phone Number

_____ _____
Insured's Employer Phone Number

☐ My child is uninsured, and I would like information regarding reduced fees (sliding fee) and/or CHIP.
- Gross Family Income per month: _____ Family size: _____
(Due to Federal Funding, we are required to request this information.)

- I, the parent or guardian, give consent for LPCC/SWVHS for treatment of the health services listed on this form that may be delivered through face-to-face and/or interactive telehealth in accordance with my child's established treatment plan, while my child is a student of the local county Board of Education his school year.
- I understand and agree with the use of clinical photography for medical records ONLY.
- I understand that not all school-based health centers are in the school and my child may be seen in a building adjacent to the school building.
- I accept responsibility for payment of all charges and fees for services rendered by Lincoln Primary Care Center/Southern West Virginia Health System to the student listed above. I further authorize that any insurance benefits be paid directly to the

institution which provided the services. I agree to the release and disclosure of medical information required to verify coverage or process insurance claims. LPCC/SWVHS will bill your insurance carrier on your behalf for charges related to the services provided by our employees in our facility. Please note that you are responsible for the full amount of your account that is not covered by insurance (except for certain government insurance plans). I understand that the services provided by the health center are billable to all insurance companies and I am responsible for any amount not paid by my insurance.

- By signing the consent form I am giving the SBHC, school nurse and my child's regular doctor (if applicable) permission to communicate and share medical information regarding my child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. Other information will only be shared with people outside of the health center staff with parental or guardian consent.
- I authorize LPCC/SWVHS and its' providers to access information about the student's prescriptions through a prescription exchange called Surescripts. This information helps the treatment team care for the patient in a safer and more efficient manner, especially if they are unable to tell the exact names and dosages of their medications.
- I authorize LPCC/SWVHS to share and receive my immunization information through West Virginia Statewide Immunization Information System (WVSIIS).
- I understand that WVSIIS is a confidential, computerized information system that keeps complete and up-to-date immunization records. LPCC/SWVHS participates with West Virginia Health Information Exchange (WVHIN). WVHIN allows providers, hospitals, pharmacies, and other health care providers and insurance companies to view all your available health records to provide you with better care to coordinate your care and/or to ensure proper payment is made for the services you receive. WVHIN's Health Information Exchange (HIE) may allow your providers to have access to life saving information in a medica emergency. By signing this form, I agree for my child to participate with the WVHIN's HIE.
- I have been provided the opportunity to review LPCC/SWVHS Notice of Privacy Practices, which sets forth my rights and the obligations of LPCC/SWVHS concerning my Protected Health Information. I have the rights to request a copy of this Notice of Privacy Practices at any time.
- LPCC/SWVHS reserves the right to revise or amend its Notice of Privacy Practices at any time, in its sole discretion, without prior notice to me. I understand that, if LPCC/SWVHS elects to amend its Notice of Privacy Practices, LPCC/SWVHS will inform me of the change at my next regular visit. LPCC/SWVHS posts a copy of its current Notice in visible location within its offices, and it also is available on the LPCC/SWVHS website at www.SWVHS.org

I understand that I may withdraw consent at any time by contacting any member of the staff in writing or by phone.

_____ _____

Signature of Parent/Legal Guardian Relationship to Student

_____

Date