*Hopkins County Health Department*
*412 North Kentucky Ave.*
*Madisonville, KY 42431*
*(270) 821-5242 or 1-800-895-8451*

Dear Parent/Guardian:

School-based health clinics are a part of the Hopkins County Health Department and are available to provide:

Sick child assessment & treatment
First aid
Required screenings such as vision, hearing & scoliosis
Required school entry/6th grade/transfer school physicals
EPSDT **(Medicaid preventive checkup)**
Dental Care **(Screening)**
**Immunizations for students who are uninsured, underinsured, or have Medicaid**
**Care plans and care for chronic illness**
Other services as needed

**The attached consent and general information form must be completed and signed in order for your child to be seen by the Hopkins County Health Department School-Based Clinic**. Some of the information required is for statistical/reporting purposes. If you have any questions as to why some information is required, please ask.

There will be times during the school year when the school-based clinic will not be open or the nurse is not available.

There is **no charge** to students for using the school-based clinic.

**NOTICE OF PRIVACY PRACTICES**

Information/data may be shared with the Family Resource Center serving your child's school, other school-based clinics, and the Hopkins County Health Department. Information collected for the school such as vision/hearing/scoliosis screenings, school physicals, and immunizations will be shared with the school. Information regarding treatment for chronic illness or emergency treatment will be provided to necessary staff. Information may be shared to coordinate follow-up care after an emergency department visit. Sharing information will be done according to FERPA and HIPPA guidelines.

GENERAL INFORMATION
PLEASE FILL IN THE FOLLOWING INFORMATION FOR STUDENT (**front and back**)
(**PLEASE PRINT**)

Last Name_____ First Name _____ Full Middle Name_____

Date of Birth _____ Gender: **Male / Female**

**Student's Social Security # _____**

**Race-**(mark all that apply) Native American ___ Asian___ Black or African American___
Native Hawaiian or Other Pacific Islander___ White___ **Is student Hispanic Y / N or Latino Y / N**

Address_____
PO Box/Street City Zip
County of Residence _____ How many people live in your house? _____

Home phone #_____

Is student covered by Kentucky Medicaid? **(Medical Card) Y / N**
If applies circle MCO: AETNA / Well Care / Humana / Anthem / Passport
**Policy # as listed on MA or MCO card: _____**

Does student have health insurance? **(Not Medicaid) Y / N** Name of Insurance _____
Does insurance cover ALL immunizations? **Y / N If not, which ones are not covered? _____**

Name of child's primary care doctor_____ phone #_____

Mother's name _____ (maiden name) _____ cell # _____ work # _____
Father's name _____ cell # _____ work # _____
Email _____

Who does the child live with?
Name _____ Relationship _____ Phone #_____

Is student in foster care? **Y / N (If yes, consent must be signed by DCBS) Case Worker _____**

In case of an EMERGENCY, if unable to contact parent, please give us at least 3 other people we can contact
(This should be same as school information) (Please contact school clinic if phone numbers change)

| **Name** | **Relationship to student** | **Home Phone #** | **Cell Phone #** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**What grade will your child be in during the 2018-2019 school year? _____.**

**Who is your child's homeroom teacher for the 2018-2019 school year? _____.**

If your child is in Preschool or Head Start, are they in the AM or PM class? _____

***Sign on back***

Please answer yes/no to the following. If the answer is yes, please explain.

1. Allergies **(medications, food, latex, etc.)** **Y / N** _____

_____

**Does your child require an EPI-PEN for his/her allergy? Y / N**

2. Current medication(s) **Y / N** _____

3. Past surgeries/hospitalizations/transfusions **Y / N** _____

4. Has your child had chicken pox? **Y / N** If Yes, date _____Was it diagnosed by a healthcare provider? **Y / N**

4. Long-term illnesses **Y / N** _____

5. Other concerns **Y / N** _____

**6.** Does anyone smoke inside the home or car? **Y / N** Are E-cigarettes smoked inside the home or car? **Y / N**

7. Has your child been in contact with a person with tuberculosis or has your child traveled to or emigrated from a foreign country with a high rate of TB (Asia, Middle East, Africa, or Latin America)? **Y / N** _____

8. Has your child had exposure to the following risk factors for lead poisoning: peeling paint in a house built before 1978, a close family member with lead poisoning, a family member with an occupation that has lead exposure, living closely to a highly traveled highway, using folk remedies containing lead, eating food stored in old pottery, chewing on paint chips or eating dirt? **Y / N** _____

**Family history (student's parents, grandparents, siblings):** diabetes, stroke, elevated blood pressure, heart disease, TB, cancer, kidney disease, seizures, sickle cell, genetic/birth defects, HIV, or mental health problem(s)

_____

_____

## CONSENT TO HEALTH SERVICES

I give my consent for _____

(Print student's name) (Birth date)

to receive services at the Hopkins County Health Department School-Based Clinic. Services might include: required school examinations, TB skin test, lead & urine test for Head start students, first aid, EPSDT screening or preventive dental screening. This consent will include permission to receive over-the-counter medications such as: Tylenol, Tums, decongestants, cough medicine, anti-nausea medicine, Ibuprofen, antihistamines, etc. Are there any over-the-counter medications that your child should not take? _____

I verify that I have received notice of privacy practice. **If Applicable**, I authorize billing for Medicaid services.

_____

**Signature of Parent/Guardian** **Date**

**(If student is in foster care, consent must be signed by DCBS Case Worker)**

**Student should return form to homeroom teacher or school clinic. Consent is for the 2018-2019 school year.**

# Child cannot be seen in the school clinic without a signature from the parent, legal guardian, or Community Base Services' (DCBS) case worker.