PARENT/GUARDAIN MUST COMPLETE AND RETURN FORM TO SCHOOL FOR CHILD TO RECEIVE HEALTHCARE SERVICES AT SCHOOL

Rural Health Services (RHS) located at 1000 Clyburn Pl, Aiken, SC has partnered with your child's school to provide healthcare (medical, and dental) at school during school hours. Healthcare services will also be offered at community locations when students are not in school. Your child will not need to miss school to receive services and services are provided regardless of ability to pay. Parents will not receive a bill.

Medical Services Include: Well child exams, medical screening (urine and blood), and head to toe examination, treatment, and nutritional counseling.

Dental Services Include: Exam, x-rays, cleanings, sealants, and Fluoride. Treatment needs will be sent home for informed parental consent prior to operative work (fillings). If the patient indicates any resistance to the dental procedure, we will discontinue the treatment.

If you want your child to participate, complete this form and return it to your child's school within the next two (2) days. **Complete all insurance and health history information.** The information can only be filled out by a parent or legal guardian and must be filled out in ink. If your child already has a dentist or doctor, you should keep going to that dentist or doctor.

Check services you want:
I want my child to be seen by _____ Medical Staff Only _____ Dental Staff Only _____ Both Medical and Dental

I want my child to have nutritional counseling provided by Rural Health Services if services are found to be beneficial _____

Child Information
School: _____ Grade: _____ Teacher: _____
Child's First and Last Name: _____
Gender: ____F ____M __Other Parent/Guardian Email: _____
Address (City, State, and Zip and Apt#): _____
Date of Birth: _____ Age: _____ Child's Social Security#: _____
Primary Phone: (____) _____ Day Phone: (____)_____ Cell: (___)_____
Name of Your Child's Primary Doctor: _____ Dentist: _____ N/A:_____

Race (circle): American Indian Alaskan Native Asian Black/African American Native Hawaiian Caucasian Other Pacific Islander Multiple Races Other Unreported/Refuse to Report

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Language (circle): English French German Italian Japanese Spanish Portuguese Sign Language Other Decline to Answer

Housing (circle): Single Family Home Homeless Multiple Family Home (Doubling Up) Transitional Housing (Shelter) Other Decline to Answer

INSURANCE INFORMATION: As the Responsible Party, I understand that my dental or medical insurance carrier or payer of my benefits will be billed for services rendered. Medicaid or private insurance is accepted as payment in full for service(s). If your child's insurance changes during the year make sure that we get an updated copy of your insurance card and/or updated insurance information.

____CHILD HAS MEDICAID:
Medicaid Provider: _____ _____
Medicaid #: _____

___CHILD HAS PRIVATE INSURANCE:
Insurance Company Name: _____ Phone # of Company: _____
Policy Holder's Name: _____ Employer: _____
Policy Holder's ID or SS#_____ Group#_____ Policy Holder's DOB: _____
Primary Phone: (____) _____ Day Phone: (____) _____ Cell: (___)_____

___CHILD HAS SEPARATE DENTAL INSURANCE:
Insurance Company Name: _____ Phone # of Company: _____
Policy Holder's Name: _____ Employer: _____
Policy Holder's ID or SS#_____ Group#_____ Policy Holder's DOB: _____
Primary Phone: (____) _____ Day Phone: (____)_____ Cell: (____)_____

CHILD IS UNINSURED (NO INSURANCE): Call (803) 380-7000 For Information and Help!

FAMILY INFORMATION: **Parent /Guardian:** _____
Address (If different from child's) _____
Home Phone: (___)_____ **Day: _(___)**_____ **Cell: _(__)**_____
Choice of Pharmacy: _____ **Address/Phone # of Pharmacy:** _____
Family Yearly Income Level: $_____ **Decline to Answer** _____ **Email:** _____

Date of the last time your child saw a dentist or doctor? Dentist: _____ Doctor: _____

Would you like any other adult to be able to give permission to treat your child? This would also allow the dental and medical team to talk about your child's health, treatment, and recommendations with this adult. If yes, please provide:
First and Last Name: _____
Phone number: _____ Relationship to child: _____

Medical History: **Write Yes (Y) or No (N) on the line provided beside the question.**
Has the student had surgery in the past? If yes, EXPLAIN why: _____
Are any of the child's teeth causing pain? _____
Does the child smoke, use tobacco and/or recreational drugs? _____
Is the student pregnant or possibly pregnant? _____
Have there been any changes in the student's health in the past year? EXPLAIN: _____
Has the Student ever been hospitalized overnight? If so list dates, and the reason? _____
Has the student had any serious or sport related injuries? _____
Does the student have any allergies (food, medication, anesthetics, latex, etc.)? If so, List: _____
Has your child been in contact with the AIDS virus or have they been tested positive for HIV? _____
Does your child take any daily medications, including over the counter or inhalers? _____. **If Yes, explain** _____.

____ High or low Blood Pressure
____ Ulcer or Acid Reflux
____ Heart Transplant
____ Pacemaker
____ Recent Blood Transfusion
____ Bacterial Endocarditis
____ Cortisone Steroid Treatment
____Heart conditions including murmur
____ Nervous Disorder or Behavioral Problems
____ Artificial Joints
_____ Stroke or mini-stroke
_____Congenital Heart Disease (Heart defects noted from birth)
_____ Anemia (including sickle cell anemia) Type: _____
_____Artificial or prosthetic heart valve, stent, or graph
_____ Epilepsy and/or Seizure
_____ Arthritis
_____ Sinus Problems (hay fever)
_____ Cancer/Radiation/Chemo
_____ Learning Disability or Special Needs
____Sexually Transmitted infection (Disease). EXPLAIN: _____
____ Asthma, Breathing Problems or lung disorder? EXPLAIN: _____
____ Kidney Trouble, EXPLAIN: _____
____Tuberculosis, MRSA, or any other infectious disease. EXPLAIN: _____
____ Asthma- List Triggers and date of last attack_____
____ Liver disease, Hepatitis, jaundice, bleeding disorder or history of Leukemia. EXPLAIN: _____
____ Does your child have any other medical problems not listed? If yes, please list and explain: _____

Authorization
1. I authorize the School-Based Dental Staff to perform diagnostic procedures and treatment as may be necessary for proper dental care, including (but not limited to) exams, x-rays, cleanings, and sealants. I also authorize the dentist to perform further treatment as indicated on the treatment plan sent home with my child.
2. I authorize the RHS School-Based Medical Staff to perform a well-child checkup to include medical examination, screening, treatment and/or behavioral health screening.
3. I authorize the RHS School-Base Medical Staff to immunize my child and/or administer flu shot if needed.
4. I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
5. I authorize the release of any information regarding my child's healthcare, advice, and treatment to another dentist, doctor, or school nurse.
6. I authorize payment of insurance benefits directly to Rural Health Services, otherwise payable to me.
7. I attest to the accuracy of the information contained within this packet. I understand that it is my responsibility to inform the RHS staff of any changes in my child's insurance and medical status at the very next appointment before any treatment is rendered.
8. I understand that services may be provided in person or virtually via telehealth.

Acknowledgment of Receipt of Notice of Privacy Practices and Authorization of PHI Disclosure
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights can be found at www.HHS.gov. By returning this form to my child's school, I acknowledge my understanding of my rights concerning HIPAA. I also am aware that treatment plans that may contain health information may be sent home with my child for my review. I understand that I may revoke this authorization at any time by contacting RHS at the contact information listed below.

Parent or Guardian Signature: _____

Date: _____

Call **(803) 219-1926** if you have questions about this program or care received on the mobile unit.