



# RHS SCHOOL-BASED HEALTH SERVICES

## CHILD ENROLLMENT FORM

Questions? 803-219-1926



Rural Health Services, Inc. (RHS) has partnered with your child's school to provide healthcare and dental services during school hours through our school-based health team. Services are provided to all students regardless of their ability to pay or if they are insured. **Parents will never receive a bill but private insurance or Medicaid will be billed.** The information must be filled out in ink by a parent or legal guardian. If your child already has a dentist or doctor, you should keep going to that dentist or doctor.

**MEDICAL SERVICES INCLUDE:**

Well-child exams, medical screening (blood), & head-to-toe examination, treatment, and nutritional counseling.

**DENTAL SERVICES INCLUDE:**

Exam, x-rays, cleanings, sealants, and Fluoride. Additional parental consent is required for operative work (fillings).

**BEHAVIORAL HEALTH SERVICES INCLUDE:**

Screening to identify behaviors that hinder success in school, home, or community. Counseling and/or intervention as needed will be provided with parental consent.

I WANT MY CHILD TO BE SEEN BY (CHECK SERVICES THAT APPLY):

Medical Staff Only  
  Dental Staff Only  
  Both Medical & Dental  
  Behavioral Health (Ridge Spring Elem. & CIL only)

**CHILD'S PERSONAL INFORMATION**

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_  
 Date of Birth :   /   /   Age: \_\_\_\_\_ Social Security : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
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 Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Primary Doctor: \_\_\_\_\_ Dentist: \_\_\_\_\_

**HELP US GET TO KNOW YOUR CHILD BETTER**

Gender at birth :  Male  Female    Gender Identification : \_\_\_\_\_  
 Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  
 Race (Check All That Apply) :  American Indian/Alaskan Native  Asian  Black/African American  Native Hawaiian  
 Other Pacific Islander  White  Prefer not to say  Multi-races \_\_\_\_\_  
 Preferred Language:  English  Spanish  Other \_\_\_\_\_ Translator needed?  Yes  No  
 Housing:  Single Family Home  Homeless  Doubling up  Shelter  Transitional Housing  Other/Prefer not to say

**INSURANCE INFORMATION (REQUIRED)**

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#: \_\_\_\_\_  
 Date of Birth :   /   /   Phone # of Policy Holder \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
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CHILD HAS SEPARATE DENTAL INSURANCE:  
 Insurance Company Name: \_\_\_\_\_ Phone # of Company: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Policy Holder's ID or SS# \_\_\_\_\_ Group#: \_\_\_\_\_  
 Date of Birth :   /   /   Phone # of Policy Holder \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
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CHILD IS UNINSURED (NO INSURANCE):  
 CALL 803-679-4243 to speak to our state-wide marketplace navigator or certified insurance application counselors.

## FAMILY INFORMATION

Parent/Guardian:

Address:  City:  State:  Zip:

Home Phone:  -  -  Cell Phone:  -  -  Email:

Preferred Pharmacy:  Family Yearly Income Level: \$

Address/Phone # of Pharmacy:   -  -

Date of the last time your child saw a dentist or doctor?

Date of Dentist:   /   /   Date of Doctor:   /   /

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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:

Full Name:  Phone #:  -  -  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 them: \_\_\_\_\_

Has your child been in contact with the AIDS virus or have they tested positive for HIV? \_\_\_\_\_

Does your child take any daily medications, including over-the-counter or inhalers? If yes, explain: \_\_\_\_\_

### Check all that apply for your child:

<input type="checkbox"/> High or low blood pressure	<input type="checkbox"/> Stroke or mini-stroke	<input type="checkbox"/> Bacterial Endocarditis	<input type="checkbox"/> Artificial or prosthetic heart valve, stent, or graph
<input type="checkbox"/> Ulcer or Acid Reflux	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Cortisone Steroid Treatment	
<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart conditions including murmur	
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Nervous Disorder/Behavioral Problems	
<input type="checkbox"/> Recent Blood Transfusion	<input type="checkbox"/> Epilepsy and/or Seizure	<input type="checkbox"/> Learning Disability or Special Needs	
<input type="checkbox"/> Sinus Problems (Hay Fever)	<input type="checkbox"/> Cancer/Radiation/Chemo	<input type="checkbox"/> Anemia (incl. sickle cell anemia) Type: _____	

Sexually Transmitted Infection (Disease). EXPLAIN: \_\_\_\_\_

Asthma, Breathing Problems or lung disorder, EXPLAIN: \_\_\_\_\_

Kidney Trouble, EXPLAIN: \_\_\_\_\_

Tuberculosis, MRSA, or any other infectious disease. EXPLAIN: \_\_\_\_\_

Asthma, Breathing Problems or lung disorder, EXPLAIN: \_\_\_\_\_

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

- 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 authorize the RHS School-Based Medical Staff to perform a well-child checkup including medical examination, screening, treatment and/or behavioral health screening.
- I authorize the RHS School-Based Medical Staff to immunize my child and/or administer flu shot if needed.
- I authorize the RHS School-Based Behavioral Health Staff to conduct screening to identify behaviors that hinder success in school, home, or community (Ridge Spring Elem. & CIL only).
- 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.
- I authorize the release of any information regarding my child's healthcare, advice, and treatment to another dentist, doctor, or school nurse/official.
- I authorize payment of insurance benefits directly to Rural Health Services.
- I attest to the accuracy of the information provided in this form. I understand that it is my responsibility to inform the RHS staff of any changes in my child's insurance and medical status on or before the next appointment.
- I understand that services may be provided in person or virtually via telehealth.

### Acknowledgement 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](http://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:   /   /

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