



**BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.**

NAME _____ DOB _____
 GRADE _____ TEACHER _____
 SCHOOL _____
 CHART #: _____

SCHOOL BASED HEALTH REGISTRATION FORM

Today's Date: _____ Review Date: _____
FOR REGISTRATION PERSONNEL ONLY – DO NOT WRITE IN THIS SPACE

Which of our centers have you visited: (Please check the location)

- Port Royal Center Hampton Center Chelsea Center Hardeeville Center School Based Health Center _____
 Sheldon Center Ridgeland Center St. Helena Center Estill Center Port Royal Same Day Health Clinic

Patient/Student Information

Last Name		First Name		Middle Initial	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
Street Address			City	State	Zip	County	
Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Undeclared				Ethnicity <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic/latino <input type="checkbox"/> Another Hispanic/latino <input type="checkbox"/> Other _____			

Parent/Guardian Information (Enter name of person financially responsible for account)

Last Name		First Name		Middle Initial	Social Security Number		
Street Address			City	State	Zip	County	
Mailing Address/PO Box			City	State	Zip	County	
Home Phone () ()	Cell Phone () ()	Work Phone () ()	Date of Birth	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Email address		Pharmacy name & location			Annual Income	Family Size	
Emergency Contact Name & Relationship to student				Phone Number			

Do you work on a Farm? <input type="checkbox"/> No <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant <input type="checkbox"/> Employed Farm-worker <input type="checkbox"/> Unemployed Farm-worker <input type="checkbox"/> Other	Housing Status <input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Other
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Insurance Company

Primary Insurance	ID #	Group #	Insurance Company Address
Name of Insured	Insured's Employer	Relationship to Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Secondary Insurance	ID #	Group #	Insurance Company Address
Name of Insured	Insured's Employer	Relationship to Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

School Based Health Center Service Fees for Uninsured

Medical/Nutrition/Behavioral Health services \$30 Annual Fee: <u>only</u> if your child is not covered by MEDICAID or other insurance. <input type="checkbox"/> Fee enclosed (uninsured) <i>If paying by check please make payable to BJHCHS, Inc.</i>	Dental services \$50 Annual Fee: <u>only</u> if your child is not covered by MEDICAID or other insurance. <input type="checkbox"/> Fee enclosed (uninsured) <i>If paying by check please make payable to BJHCHS, Inc.</i>
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Acknowledgment: I acknowledge receipt of the: Notice of Privacy Practice **Yes** Patient Rights and Responsibilities **Yes**

Signature of person providing information: _____ **Date:** _____

The attached CONSENT FOR TREATMENT & Health Information forms must be completed before your child will be seen. Thank you.

Student Health Information

Chart # _____

Student's Name: _____ Birthdate: ____ / ____ / ____ Grade: _____

MEDICAL HISTORY

Does this child have a regular doctor? YES NO

If YES, who? _____

If NO, what is your usual source of medical care? _____

Date of this child's last Physical/medical check-up? _____

Where? _____

Are child's immunizations (shots) up to date? YES NO

Is a copy of the shots record on file at the school? YES NO

Has this child been seen in the emergency room in the past year? YES NO If YES, why? _____

Has this child ever been in the hospital? YES NO

When? _____ Why? _____

Has this child ever had surgery? YES NO When? _____

What kind? _____

Does this child have Behavioral/Developmental/School problems? (learning delays, ADHD, Down's Syndrome, Autism, etc.)

YES NO If YES, what? _____

Please list any of this child's allergies (medicine, food, latex, pollen, insects, dust, etc.): _____

Does your child take any daily medications? YES NO

If YES, what medication and how often taken? _____

Do you have well water? YES NO

FAMILY HEALTH HISTORY:

If any of this child's relatives suffer from any of the following illnesses, please fill in the relationship to the child, and note if they are deceased. (Example: Grandmother, Mother, Aunt, Sister, etc.)

Diabetes _____

Cancer _____

Heart Disease _____

Stroke _____

Tuberculosis _____

Seizures _____

Asthma _____

Allergies _____

DENTAL HISTORY

Does this child have a regular dentist? YES NO

If YES, who? _____

Date of this child's last dental check-up? _____

Has this child ever had difficulties associated with dental treatment? YES NO If YES, what kind of difficulties? _____

Does your child have to take medication before being checked by a dentist? YES NO If YES, what kind of medication? _____

Has this child ever had any of the following conditions: (please circle correct answer)

Rheumatic Fever of Rheumatic Heart Disease Yes No

Heart Valve Problems/Surgery Yes No

Heart Murmurs Yes No

Heart Problems/Congestive Heart Failure Yes No

Stroke Yes No

Jaundice Yes No

Kidney Disease Yes No

Prolonged Bleeding Yes No

ADD/ADHD Yes No

Autism Yes No

Down's Syndrome Yes No

Tuberculosis Yes No

Diabetes Yes No

Anemia Yes No

Seizures Yes No

Hepatitis Yes No

Eczema Yes No

Asthma Yes No

Medication/Inhaler Yes No

Chicken Pox Yes No

Ear Infections (frequent) Yes No

Signature of person completing this form _____ **Date** _____

/ /

Student Name: _____ DOB: _____ School: _____

CONSENT FOR TREATMENT for School Based Health Services

I, _____, parent or guardian of _____, hereby authorize Beaufort Jasper Hampton Comprehensive Health Services, Inc. School Based Health Center (SBHC) to provide medical, telemedicine, dental, nutrition, social worker/behavioral health services including, but not limited to, a medical examination, health education, behavioral health screening. Treatments and medications may be ordered as advised by the attending professional.

I understand that Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS) Provider may request and use prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes only.

I understand that I am giving consent to bill my insurance carrier for services provided in the SBHC and to release information about my child's medical condition as may be ordained necessary or advisable by the attending professional. I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles and co-pays. If child is uninsured, I understand that I will be liable to pay the annual school based fees applicable to the services provided. I understand that this consent is voluntary and is valid only for services provided at the School Based Health Center. I understand this consent form is valid, until I revoke it in writing.

I agree and give my consent for my child to receive the following services:

Parent or guardian signature is required for EACH service you wish your child to receive.

Medical/Nutrition Services

Signature of parent/guardian: _____ Date: _____

Behavioral Health Services *Please note that prior to counseling sessions are initiated the student will first be evaluated by the Pediatrician or Family Nurse Practitioner. In order for the student to receive Behavioral Health Counseling Services consent MUST be given for Medical services (sign line above and below)

Behavioral Health counseling services including behavioral health screening, assessment, and/or counseling. I understand that no mental health medications will be prescribed without my explicit permission. An appointment with the psychiatrist will be made available to discuss whether my child would benefit from the use of psychiatric medications.

Signature of parent/guardian: _____ Date: _____

Dental Services AND Dental Anesthesia Consent

Dental treatment provided to your child while in school may require use of local anesthetics. This may result in a traumatic ulceration of the lip when children chew their numb lip after a dental appointment. If this should occur we recommend over the counter Anbesol, Orajel or Orabase with benzocaine as topical anesthetics. Healing usually occurs within two (2) weeks. Severe trauma usually requires antibiotics.

Signature of parent/guardian: _____ Date: _____