**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 ☐ Male ☐ Female | Date of Birth | Social Security Number |
|---|---|---|---|---|---|
| **Street Address** | **City** | **State** | **Zip** | **County** | |
| **Race** ☐ Black ☐White ☐Hispanic/Latino ☐Asian ☐ American Indian ☐Pacific Islander ☐ Native Hawaiian ☐ Undeclared | | **Ethnicity** ☐ Not Hispanic ☐ Mexican-Hispanic/latino ☐ Cuban-Hispanic/latino ☐ Puerto Rican-Hispanic/latino ☐ Another Hispanic/latino ☐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** ☐Male ☐ Female | **Marital Status** ☐Single ☐ Married ☐Separated ☐ Divorced |
| **Email address** | **Pharmacy name & location** | **Annual Income** | **Family Size** | | |
| **Emergency Contact Name & Relationship to student** | **Phone Number** | | | | |

| Do you work on a Farm? | Housing Status |
|---|---|
| ☐ No ☐ Seasonal ☐Migrant ☐ Employed Farm-worker ☐Unemployed Farm-worker ☐ Other | ☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐Other |

## Insurance Company

| Primary Insurance | ID # | Group # | Insurance Company Address |
|---|---|---|---|
| **Name of Insured** | **Insured's Employer** | **Relationship to Responsible Party** ☐ Self ☐ Spouse ☐Child ☐ Other | |
| **Secondary Insurance** | **ID #** | **Group #** | **Insurance Company Address** |
| **Name of Insured** | **Insured's Employer** | **Relationship to Responsible Party** ☐ Self ☐ Spouse ☐ Child ☐ Other | |

## School Based Health Center Service Fees for Uninsured (No insurance)

If your child does **not** have insurance, you may apply for our Slide Fee Discount Program. Proof of income will be required to receive discount.

| | |
|---|---|
| ☐ **Yes,** I would like to complete Slide Fee Program application and turn in proof of income. I understand that discount program will not be applied until Slide fee application is completed and proof of income is submitted. | ☐ No, I do **not** wish to apply for discount program and understand that I will get a bill for services rendered. |

**Acknowledgment:** **I acknowledge receipt of the: Notice of Privacy Practice** ☐ **Yes** **Patient Rights and Responsibilities** ☐ **Yes**

***Notice of Privacy Practice and Patient Rights and Responsibilities available to view online at https://forms.gle/zC7iFHUcn7rvbMFp8***

**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.***

Revised 6/2024_AJ

## ***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)**

| Condition | | |
|---|---|---|
| Rheumatic Fever of Rheumatic Heart Disease | Yes | No |
| Heart Valve Problems/Surgery | Yes | No |
| Heart Murmurs | Yes | No |
| Sickle Cell Anemia | 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 the following below health services as indicated by my signature. I understand that I do not have to be present during the time services are rendered.

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 service fee per visit 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***

Medical services include but not limited to, medical exams, evaluation and treatment of acute and chronic conditions, nutrition counseling, health education, and health screenings. Laboratory tests, diagnostic imaging, treatment, and medications may be ordered as advised by the attending professional.
**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 parent/guardian consent MUST be given for Medical services (sign line above and below)***
Behavioral Health counseling services including mental health screening, assessment, Cognitive Behavioral Therapy (CBT) and/or counseling. I understand that no mental health medications will be prescribed without my explicit permission. An appointment with the psychiatrist may 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 services include, dental exams, medications, x-rays, cleanings, fluoride, sealants, extractions, Silver Diamine Floride (SDF), and any other restorative work as needed. 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**: ___________