



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"/> Mexican-Hispanic/latino <input type="checkbox"/> Cuban-Hispanic/latino <input type="checkbox"/> Puerto Rican-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?

- No Seasonal Migrant Employed Farm-worker
 Unemployed Farm-worker Other

Housing Status

- 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 <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 (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 No Patient Rights and Responsibilities Yes No

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.

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

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 Fluoride (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:** _____



BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME: _____

DOB _____ CHART # _____

DATE: _____

SCHOOL: _____

Dear Parent,

Welcome to the BJHCHS, Inc. School Based Health Center. In order to provide the most comprehensive services possible for your younger elementary aged child, please provide the following information prior to their first visit.

1) Who lives in the home? (check all that apply)

a. Both parents Mom Dad

Stepparent Grandparent

b. Number of brother _____

Ages _____

Number of sisters _____

Ages _____

c. Extended family members
(grandparent, cousin, etc):

2) Does anyone in the home smoke? Yes No

If yes, who: _____

a. Inside Outside

3) Any pets? inside outside

a. Dogs Cats Other? _____

4) Does child attend daycare? Yes No

In the After school program? Yes No

5) Does your child have any current health problems?

a. _____

6) Does your child drink milk at home? Yes No

a. How many cups per day _____

b. Type of milk: Whole 1% 2% _____

Nonfat Soy Rice _____

7) Is your child a picky eater? Yes No

8) How many times per week does your child eat fast food (Hardee's, McDonald's, etc.) ?

a. 1 2 3 or more Never

9) How many soft drinks do they consume each day?

a. _____ 8 oz. cup

b. _____ 12 oz. can

c. _____ 20 oz bottle

d. _____ none (Water only)

10) How many servings of fruits/fruit juice and vegetables do they get in a day?

a. Fruit/Fruit Juice _____

b. Vegetables _____

11) How many hours a day do they spend

a. Watching TV _____

b. On the Computer _____

c. Playing Video games _____

12) Does your child

a. Know their first and last name? Yes No

b. Play well with other children? Yes No

c. Continue to use "baby talk"? Yes No

d. Speak so you can understand them 100 % of the time? Yes No

e. Dress by his or herself (at least on weekends)?
 Yes No

If you have any other information you would like to add, as well as questions or concerns, please feel free to write in down in the area below. I look forward to meeting with your child in the next few weeks.

Sincerely,

School Based Nurse Practitioner