SCHOOL BASED HEALTH / DENTAL CENTERS
ENROLLMENT FORM & INFORMATION
Kent County Public Schools

Dear Parent/Guardian:

As a student in the Kent County Public School system (KCPS), your child has access to the Choptank Community Health SCHOOL BASED HEALTH & DENTAL CENTERS at the following KCPS site:

Rock Hall Elementary School.

The mission of the Centers is to **improve the health of students and faculty**, **increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source** of **quality health care** that works in collaboration with your child's doctor and the school nurse.

Choptank Community Health recognizes the connection between health and positive academic outcomes. CCHS is pleased to partner with Kent County Public Schools and Kent County Health Department to ensure that students are healthy and ready to learn.

Your child can receive treatment right at school! Common complaints and reasons for visit to the School Based Health Center include:

- Congestion/cough
- headaches
- health risk assessments
- skin itch/rash
- sore throat evaluation
- strep throat tests
- counseling referral
- telehealth/virtual visits
- health education
- prescriptions
- physicals
- sports physicals
- earaches
- referrals to specialists
- pain or injuries
- shortness of Breath
- nausea/vomiting evaluation
- blood pressure screenings

Services Available in the School Based Health Centers

- Diagnosis and treatment of illnesses
- Behavioral health service referral
- Nutrition services and discussion of healthy choices

Services Available in the School Based Dental Programs

As a student in the **Kent County Public School** system, your child has access to the **School Based Dental Program**. The program is a partnership between the Public Schools, County Health Departments, and Choptank Community Health System (CCHS).

Services may include:

- dental screening
- dental sealants
- polishing/cleaning
- oral Health Education
- fluoride (may be applied twice)
- dental emergency referrals

The School Based Dental program does not take the place of your primary dentist. A dental hygienist will screen your child to determine which services will be provided or if a referral is necessary. The hygienist provides care in the school setting that promotes healthy teeth and gums. Your child should go to your dental office for a complete exam with x-rays as often as recommended by your dentist.

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ADDITIONAL INFORMATION

The mission of the School Based Health Centers is to **improve the health of students and faculty**, **increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source** of **quality health care** that works in collaboration with your child's doctor and the school nurse.

SERVICES: In addition to the services mentioned above, SBHC providers can assist in managing chronic illnesses, conduct *Healthy Child Chats*, provide health education, referrals to specialists and sports physicals for school endorsed sports. Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report on the visit is shared with your child's primary health care provider.

COST: Federal and state regulations require all providers, including Choptank Community Health (CCHS), to bill all patients for School Based Health Center program services. The Medicaid programs cover School Based Health Center charges. If your child has health insurance, we will bill the insurance company for health services and follow the billing requirements associated with your plan. Depending on your insurance plan, you may receive a bill from CCHS for copays, unmet deductibles and any non-covered services. If CCHS is not a participating provider with your insurance plan, you will be billed directly for services. If you do not have insurance, we offer a sliding fee scale. Finally, the cost associated with lab services will be billed to your insurance. Bills for these tests will come directly from the lab company.

ENTERING INSURANCE INFORMATION ON THE ENROLLMENT: Please provide as much information as possible regarding your child's insurance. Examples include:

SLIDING FEE PROGRAM: The enrollment form has an area to complete to apply for our Sliding Fee Program, if you are interested. Patients on the sliding fee program can receive discounts that will be billed based upon their income. All patients and their families are eligible to apply for the sliding fee program, even if they have insurance.

ENROLLMENT: All Public School students can enroll in the program. Please complete the attached enrollment form. Return it to the school nurse or the Health Center. Once your child is enrolled in the Health Center, they will not need to re-enroll each year.

If you have any questions about the program, please contact CCHS at (410) 479-4306, ext. 1038

For after-hours emergencies, please call 443-329-9920 to reach the Choptank on call provider.

CHOPTANK community health
see how healthy you can be!

School Based Health Center
Enrollment/Update Form
MEDICAL & DENTAL SERVICES

OFFICE: Entered: _____ ☐ Post ☐ Scan
LC: _____ NA: _____
LP: _____ BW: _____
E:____ I:____ SF:____ T:____
P:____ FI2:____ OHI:____ S:____

____ I want to enroll my child in the School Based Health Center and the School Based Dental Program.

____ I want to enroll/update my child in the School Based Health Center Only.

____ I want to enroll/update my child in the School Based Dental Program Only.

My child is a student at: _____School Grade: _____ Homeroom Teacher: _____

STUDENT INFORMATION

NAME: _____
ADDRESS: _____
_____
DOB: _____ Male / Female
SOCIAL SECURITY #: _____
RACE: _____ HISPANIC/LATINO?: YES / NO
PREFERRED LANGUAGE: _____
DOCTOR: _____ PHONE: _____
DENTIST: _____ PHONE: _____
PHARMACY: _____ PHONE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____
RELATIONSHIP: _____
PREFERRED LANGUAGE: _____
#1 PHONE: _____
#2 PHONE: _____
EMAIL: _____
OK to TEXT?: YES / NO
EMERGENCY CONTACT: _____
RELATIONSHIP: _____
PHONE: _____ PHONE: _____

HEALTH INSURANCE

INSURANCE NAME: _____
POLICY/MEMBER ID#: _____
GROUP #: _____
SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____/_____/_____
CLAIMS ADDRESS: _____
_____

DENTAL INSURANCE

INSURANCE NAME: _____
POLICY/MEMBER ID#: _____
GROUP #: _____
SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____/_____/_____
CLAIMS ADDRESS: _____
_____

No Insurance? Would you like to apply for the Sliding Fee?: YES / NO Household # of People?: ____ Income: $_____ /yr.

HEALTH/DENTAL HISTORY

DAILY MEDICATIONS: _____

ALLERGIES to MEDICATION / FOOD / ENRIVONMENTAL : _____

YES / NO HAS YOUR CHILD HAD ANY RECENT HOSPITALIZATIONS OR PREVIOUS SURGERIES?
IF YES, PLEASE LIST: _____

YES / NO DOES ANYONE IN THE HOME SMOKE? YES / NO DRUG/ALCOHOL ADDICTION?

YES / NO HAS YOUR CHILD COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO HAS YOUR CHILD SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: ____/____/_____

Complete & Sign Page 2

STUDENT Name: _____ **DOB:** _____

STUDENT HISTORY

HAS CHILD EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES	NO	ADD/ADHD
YES	NO	ANEMIA
YES	NO	ASTHMA/BREATHING
YES	NO	BLOOD DISORDER
YES	NO	CANCER
YES	NO	DEVELOP. DISABILITY
YES	NO	DIABETES
YES	NO	HEADACHES/MIGRAINE
YES	NO	HEARING/VISION
YES	NO	HEART PROBLEMS
YES	NO	HIGH BLOOD PRESSURE
YES	NO	HIV/AIDS
YES	NO	KIDNEY/BLADDER
YES	NO	LEAD POISONING
YES	NO	LIVER PROBLEMS
YES	NO	MENTAL ILLNESS
YES	NO	OBESITY
YES	NO	SEIZURES/EPILEPSY
YES	NO	SKIN PROBLEMS
YES	NO	STOMACH PROBLEMS
YES	NO	STROKE
YES	NO	THYROID PROBLEMS
YES	NO	TOOTH DECAY
YES	NO	TUBERCULOSIS

OTHER: _____

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER (parent, sibling, grandparent) EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES	NO	ADD/ADHD	Who?: _____
YES	NO	ANEMIA	Who?: _____
YES	NO	ASTHMA/BREATHING	Who?: _____
YES	NO	BLOOD DISORDER	Who?: _____
YES	NO	CANCER	Who?: _____
YES	NO	DEVELOP. DISABILITY	Who?: _____
YES	NO	DIABETES	Who?: _____
YES	NO	HEADACHES/MIGRAINE	Who?: _____
YES	NO	HEARING/VISION	Who?: _____
YES	NO	HEART PROBLEMS	Who?: _____
YES	NO	HIGH BLOOD PRESSURE	Who?: _____
YES	NO	HIV/AIDS	Who?: _____
YES	NO	KIDNEY/BLADDER	Who?: _____
YES	NO	LEAD POISONING	Who?: _____
YES	NO	LIVER PROBLEMS	Who?: _____
YES	NO	MENTAL ILLNESS	Who?: _____
YES	NO	OBESITY	Who?: _____
YES	NO	SEIZURES/EPILEPSY	Who?: _____
YES	NO	SKIN PROBLEMS	Who?: _____
YES	NO	STOMACH PROBLEMS	Who?: _____
YES	NO	STROKE	Who?: _____
YES	NO	THYROID PROBLEMS	Who?: _____
YES	NO	TOOTH DECAY	Who?: _____
YES	NO	TUBERCULOSIS	Who?: _____

OTHER: _____

Additional Information: _____

_____

_____

- I understand that my signature gives consent for the CCHS School Based Health/Dental Center Providers to treat my child and to communicate with my child's primary health care provider. I give CCHS permission to call my home, leave a message regarding healthcare information. CCHS may also mail healthcare information to my home.
- I understand that my child's health information will be used for treatment, payment and health care operations.
- I recognize that school directories will be used to obtain information left blank on the enrollment form.
- My child's immunization record may be shared between the School Nurse and the School Based Health/Dental Centers. For the purposes of care coordination and case management, School Clinical Staff will have access to the SBHC/SBDP health records and School Clinical Staff shall share health information with the SBHC/SBDP staff. School Clinical Staff are required to treat the information in the SBHC/SBDP health record as confidential and comply with the HIPAA Privacy Rule and the FERPA Act.
- I understand the student may request that visits remain confidential. Maryland Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, or contraception. Students age 12 and over may receive behavorial health services without parental consent. Under no circumstances, do SBHC/SBDP records become part of the student's school health record.
- I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles.
- I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. If I do not have insurance, visit costs will be billed for the full cost of services or at a reduced rate with a sliding fee discount, if applicable. I will be offered a Sliding Fee Application whether or not I have health/dental insurance.

Parent/Guardian Signature: _____ Date: _____

PLEASE RETURN COMPLETED ENROLLMENT TO YOUR SCHOOL NURSE. THANK YOU!

Documented and reviewed by: _____