

Health History (to be completed by parent/legal guardian):

Medications (home and school, daily and as needed):

Name of medicine:	Dose (mg):	When taking:	Why taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

My child does not take any medications (including pills, liquid medicine, inhalers, nose sprays, medicine patches, or over-the-counter medicine)

Allergies:

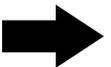
Does your child have any allergies? (please check and explain): No Yes

Allergic to:	Reaction:	Recommended Treatment: (EpiPen, Benadryl, call 911, etc)
<input type="checkbox"/> Medication: _____		
<input type="checkbox"/> Food: _____		
<input type="checkbox"/> Insect stings/bites: _____		
<input type="checkbox"/> Latex _____		
<input type="checkbox"/> Acrylic/plastics _____		
<input type="checkbox"/> Other: _____		

Medical Problems and Health Concerns:

Check all that apply and explain below:

General: <input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Chicken Pox disease (age:____)	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Immunocompromised: _____	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Overweight
<input type="checkbox"/> Speech problems	<input type="checkbox"/> Dizziness/Fainting/Passing out	
<input type="checkbox"/> Other general problems/concerns: _____		
Skin: <input type="checkbox"/> Eczema	<input type="checkbox"/> Other skin problem: _____	
Eyes, Ears, Nose, Throat, Mouth:	<input type="checkbox"/> Cleft Lip/Palate (circle)	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Hay Fever/Seasonal Allergies	<input type="checkbox"/> Vision problem; Glasses/Contacts (circle)	<input type="checkbox"/> Hearing problem
<input type="checkbox"/> Has hearing aid for Right/Left ear (circle)	<input type="checkbox"/> Other eye, ear, nose, throat, mouth problem: _____	
<input type="checkbox"/> Ear tubes (date: _____)		
Heart: <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Heart Disease	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Other heart problem: _____		
Blood: <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Sickle Cell Trait	<input type="checkbox"/> Clotting disorder: _____
<input type="checkbox"/> Other blood disorder: _____		
Endocrine, Hormones	<input type="checkbox"/> Other endocrine problem: _____	
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-Diabetes		
Brain, Nervous System: <input type="checkbox"/> ADD/ADHD (circle one)	<input type="checkbox"/> Autism	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Headaches (frequent)	<input type="checkbox"/> History of Guillain-Barré Syndrome	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Sensory Processing Disorder	<input type="checkbox"/> Other Learning Disability: _____	<input type="checkbox"/> Concussion
<input type="checkbox"/> Other brain or nervous system problem: _____		<input type="checkbox"/> Seizures (Epilepsy)



Psychological, Mood: Anxiety Bipolar disorder Depression Eating disorder
 History of hurting self History of suicide attempt(s)
 Obsessive Compulsive Disorder Other psychological or mood problem: _____

Reproductive, Genital: Pregnant Other reproductive or genital problem: _____

Bones, Muscles:
 Osgood-Schlatter disease Scoliosis Other bone or muscle problem: _____

Lungs and Breathing: Asthma Cystic Fibrosis
 Tobacco use: Cigarettes Cigars Smokeless tobacco (chew, snuff)
 Tuberculosis (TB): Active TB - age _____ Latent TB - age _____ Completed TB treatment - date _____
 Other lung or breathing problem: _____

Stomach, Digestion, Liver:
 BM (stool) in pants GERD (acid reflux) Liver disease Other GI or stomach problem: _____

Bladder, Urinary, Kidney:
 Kidney disease Wetting in pants: Day Night Other bladder or urinary problem: _____

Please **explain any medical problems** checked in the medical problems and health concerns section: _____

Immunizations:

Did the student receive 2 or more doses of the seasonal influenza vaccine since July 1, 2010? (if unsure, check "No")
 Yes No

Does the student live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as an isolation room of a bone marrow transplant unit)? Yes No

Has the student received a MMR, Varicella, or Flumist influenza vaccine in the last 30 days? Yes No

For students under 5 years old, in the past 12 months, has a healthcare provider told you that he or she had wheezing?
 Yes No

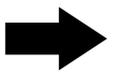
History of serious vaccine reaction? Yes No

Privacy Practices, Authorization to Release Information, & Insurance Information

Notice of Privacy Practices Acknowledgement: I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for CPH, NCH, OhioHealth, OSU and PrimaryOne Health at any CCS school building. I know that I can also view them online at <http://columbus.gov/schoolbasedhealthservices/> Copies of the consent form are available at my child's school and blank forms are also available online at <http://columbus.gov/schoolbasedhealthservices/>

Authorization to Release Information: I hereby authorize CPH, NCH, OhioHealth, OSU and/or PrimaryOne Health to share information with the CCS school nurse(s) about my child's physical and/or mental condition. Administered immunizations will be entered into the statewide immunization information system (*Ohio ImpactSIIS*). Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987). The School-Based Supplemental Health Services may use student health records to evaluate the quality of care provided and the effectiveness of offering these services. My child's records are protected and can only be accessed by authorized users with restricted access. I understand that this authorization will remain valid throughout the 2015-2016, 12 month academic year unless revoked by me. I may revoke this authorization at any time by providing written notice of my intent to revoke to the School-Based Supplemental Health Services.

Insurance Information: Insurance or other healthcare coverage programs are billed whenever possible to help cover the costs of care. Some School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay. I give CPH, NCH, OhioHealth, OSU and PrimaryOne Health the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which a benefit may be available to pay for services provided to my child through the School-Based Supplemental Health Services.



Consent for Services

By signing this **Consent for Health Services/Treatment**, I agree to the terms and conditions regarding the **Authorization to Release Information** and **Assignment of Insurance Benefits** as explained in this consent form. I also acknowledge that I have received the information about how to receive **Notice of Privacy Practices** as explained in this consent. I have received and understand the available services as described in the **School-Based Supplemental Health Services Information for Parents and Students** handout, which is attached separately.

X _____ X _____ X _____ X _____
Parent/Guardian *Printed Name* Parent/Legal Guardian *Signature* Date Phone

Relationship to Student: Mother Father Legal Guardian

-OR-

X _____ X _____ X _____ X _____
Student (Patient) *Printed Name* Student (Patient) *Signature* (if 18 years or older) Date Phone

*Any reference to 'my child' means 'myself' once a minor turns 18 years old

Health Insurance

Please check which insurance carrier your child is covered by, or sign below if you don't think your child has insurance. Some School-Based Supplemental Health Services are provided at no cost to families whether or not a student has insurance or the ability to pay.

Medicaid Managed Care Plans (check one below): Managed Care ID#: _____



Ohio Medicaid:  MEDICAID # (12 digits): _____

The student does not have health insurance (sign here for hardship waiver)
I am unable to pay for health services: X _____

Private Insurance (other than Medicaid):
Information from insurance card: Insurance company: _____
Subscriber ID or member #: _____ Group #: _____
Name of person under whom child is covered: _____ Birth date of insured adult: _____
Phone # on insurance card: _____
Claims address on insurance card: _____

Please Note:

Please note that the **School-Based Supplemental Health Services are completely optional**. School nursing and emergency services will still be provided as always whether you consent to the School-Based Supplemental Health Services or not.

The School-Based Supplemental Health Services are an excellent way to keep your child healthy and in school! If there is anything keeping you from enrolling your child in this service or if you have any questions or need help with this form, please contact your school nurse.

FOR OFFICE USE:
____ CPH AOD ____ CPH IZ ____ NCH BH ____ OhioHealth
____ CPH Sealants ____ CPH flu, Tdap ____ NCH Primary Care ____ PrimaryOne Health Vision ____ OSU Dental