MOUNTAIN COMPREHENSIVE HEALTH CORPORATION SCHOOL BASED CLINICS

Consent for School Services

The Providers and Mountain Comprehensive Health Corporation will offer medical services that include, but are not limited to acute care, preventive services, school physicals, medications for minor illnesses and emergency treatment as needed. Minimal (waived) laboratory tests will be provided at the School Based Clinic such as strep screen, flu swab and urine dip when requested by a parent or if a child comes to the clinic with symptoms indicating the need for a lab test, or if it's a required part of the physical exam. Please review this form carefully and complete all information that is requested. Return the form to your child's teacher. The Providers cannot/will not provide service to your child without this signed consent (except for emergency first aid). This consent does not cover Immunizations. The consent can be withdrawn at any time by the parent or guardian by informing the provider in writing. A special immunization consent is attached with this packet if you would like for your child to participate in a special vaccine day if scheduled at your child's school. Please complete this consent if you would like for your child to receive vaccines if needed when this special vaccine day is determined. You will be notified in writing of the special vaccine clinic dates.

For more information please go to www.mchcky.com.

School _____

_____ _____ _____/_____/_____
Student's Name (Last, First, Middle) Student's Social Security # Student's Birthday

_____
Student's Address City State Zip

_____ _____
Insurance Provider Policy/ID Number

_____ _____ _____ _____
Home Phone Number Parent's Name Daytime Phone Number Mobile Phone Number

_____ _____ _____ _____
Legal Guardian Parent's Name Daytime Phone Number Mobile Phone Number

Emergency Contact: (Other than those listed above)

_____ _____ _____
Name of Emergency Contact Phone Number Relationship to Student

____ Yes. I give my consent for my child, _____ to receive services at the School Based Clinic
Child's Name

____No. I do not wish for my child, _____to receive services at the School Based Clinic.
Child's Name

____Yes. I am giving consent for my child, _____to receive a wellness exam (excludes Immunizations) at the School Based Clinic. Child's Name

____Yes. I am giving consent for my child, _____to receive Services at the School Based Clinic by using a Telemedicine provider. Child's Name

*** Please see attached Information sheet for more details about our new telemedicine Program.**

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Social Security Number **Date of Birth**

School Name
_____

MCHC School Based Clinics

PATIENT INFORMATION -> *PLEASE COMPLETE ALL INFORMATION*

Last Name:	First Name:	Middle:	Previous Last Name:	Nickname:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security Number: _____	Date of Birth: / /	Sex: ❑ Male ❑ Female

Physical Address:	City:	State:	ZIP Code:
Mailing Address \ PO Box:	**City:**	**State:**	**ZIP Code:**

Language: ❑ English ❑ Spanish ❑ Other:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	Student Status: ❑ Full-Time ❑ Part-Time

Home Phone: ( )	Daytime Phone: ( )	Alternate Phone: ( )

Email Address:

INSURANCE -> *WHICH INSURANCE SHOULD BE BILLED FOR TODAY'S VISIT?*

PRIMARY INSURANCE: ❑ NONE ❑ WORKERS COMP:_____ ❑ AETNA
❑ WELLCARE ❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH
❑ OTHER:_____

SECONDARY INSURANCE: ❑ NONE ❑ WORKERS COMP:_____ ❑ AETNA
❑ WELLCARE ❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH
❑ OTHER:_____

Are you homeless? If **YES**, what best describes your current situation?

❑ Staying with Friends/Family ❑ Shelter ❑ Street ❑ Transitional ❑ Yes ❑ No

If **NO** do you live in Public/Assisted Housing Yes ❑ No

Race: ❑ **White** ❑ **Black/African American** ❑ **American Indian/Alaskan Native** ❑ **Asian**
❑ **Native Hawaiian/Pacific Islander** ❑ **More Than One Race**

Ethnicity: ❑ **Hispanic** ❑ **Not Hispanic** **Number in Household:**_____ **Annual Household Income:**_____

SLIDING SCALE ->

MCHC offers a sliding scale based on income, regardless if you are insured. To review income guidelines, go to www.mchcky.com or call (606) 633-4871 for more information.

Are you interested in sliding scale? **YES ❑** **NO ❑**

Someone from MCHC Will Contact you to obtain additional Information to complete your Sliding Scale Application.

MOUNTAIN COMPREHENSIVE HEALTH CORPORATION
SCHOOL BASED CLINICS

IMMUNIZATION
CONSENT

_____

Name of Patient **Date of Birth**

I consent to have the above listed patient receive required vaccinations at the school based clinic special vaccine clinic. A copy of the Vaccine Information Sheet (VIS) regarding the vaccine(s) received will be given to your child to bring home after the immunization is given for your review. By signing this consent, I understand the risks and potential side effects of this immunization. I understand that this visit will be billed to the appropriate insurance plan and agree to be responsible for any co-pays and/or deductibles that remain from this visit.

REASON FOR TREATMENT: <u>OFFICE VISIT FOR PREVENTIVE EXAM AND/OR VACCINATION VISIT</u>

Consent is given for medical treatment as is necessary to receive the required vaccinations, for financial responsibility, and to authorize MCHC to release to Third Party Sources information necessary to obtain payment for services rendered.

_____ _____

CONSENTING PERSON RELATIONSHIP TO PATIENT

_____

DATE

Immunization Records and Other Medical Information Needed For School Based Clinic Documentation

Immunization Records

The MCHC School Based Clinic that is being offered at your child's school needs to have proof of your child's immunizations. Please provide us with the name and phone number of the location where your child received their immunizations. This necessary information will allow us to provide quality care for your child at the School Based Clinics.

Please provide the name and phone number of any location where your child has received Immunizations.

Name _____ Phone Number _____

Name _____ Phone Number _____

Other Medical Information

The following list of medications will be on hand at the School Based Clinic to be administered by the providers after your child's complaint has been evaluated. Please review the following list of medications and place a check mark by the ones you will allow your child to have.

Acetaminophen (Generic Tylenol)	_____	Ibuprofen (Generic Advil)	_____
Aloe Vera Gel	_____	Sore Throat Spray	_____
Anti-Diarrhea Tablets (Generic Imodium)	_____	Sterile Eye Drops	_____
Anti-Nausea Liquid	_____	Triple Antibiotic Ointment	_____
Blistex	_____	Tussin (Generic Robitussin)	_____
Calamine Lotion	_____	Tussin DM	_____
Cough Drops	_____	Orajel (Multi-Action)	_____
Diphenhydramine (Generic Benadryl)	_____	Antacids (Liquid/Chewable)	_____
Hydrocortisone 1% Cream	_____	Glucose Gel/Tablets	_____
Bee Sting Swabs	_____		

Please list any medication your child is taking for a long term illness: _____

What is your preferred pharmacy:_____

Does your child have any allergies to foods, medications, or environmental pollens? __Yes __No

If yes, please list the allergies:_____

When was the last time your child was seen by a doctor? _____
Date Doctor's Name

_____
Address Phone Number

Any Hospitalizations? ____ (If so please specify)_____
Reason

_____
Where Physician Date

Does your child use any of the following substances?

Tobacco? ___Yes ___No Alcohol? ___Yes ___No Drugs? ___Yes ___No

Telemedicine

Mountain Comprehensive Health Corporation is now offering Telemedicine Services!

What is Telemedicine?

Telemedicine (also referred to as "telehealth" or "e-health") allows health care professionals to evaluate, diagnose and treat patients in clinic locations using telecommunications technology. Telemedicine allows patients to access medical expertise quickly, efficiently and without travel. Telemedicine provides more efficient use of limited expert resources who can "see" patients in multiple locations wherever they are needed without leaving their facility. Telemedicine will allow for your child to be seen, even when a provider is not physically on-site with the assistance of a trained and qualified Medical Assistant.

What does it mean for my child?

By utilizing Telemedicine in School-Based Clinics, MCHC will be able to provide every child with healthcare from a Medical Professional. Your child will be able to be examined by a Provider without having to leave school. This allows Providers to be able to prescribe treatments and issue medical excuses. Providers will contact parents concerning the health of their child and/or schedule a clinical visit for further examination; allowing your child to spend more time in the classroom for education so you can have peace of mind.

How does it work?

Telemedicine uses the latest HIPAA compliant medical technology to utilize state-of-the-art visual and audio equipment to ensure your child has the best and most accurate examination possible. MCHC uses a closed circuit connection for the best audio and video quality; also, to ensure that your child's information is safe, secure, and seen by only appointed Medical professionals. A Medical Assistant will be present to utilize these tools so that the Provider doing the examination from a MCHC clinic can focus solely on the needs of your child while protecting your child's rights and privacy. Parents will be contacted in the event their child sees a Provider.

Questions? Who to Contact:

School-Based Program Coordinator
Angela Howard - (606) 634 – 9292
ahoward1@mtncomp.org
Mountain Comprehensive Health Corporation
226 Medical Plaza Lane
Whitesburg, KY 41858 (606) 633 - 4871