Wilson Area School Health

Forest Hills Middle School
1210 Forest Hills Road NW
Wilson, NC 27893
252-360-0769

Fike High School
500 Harrison Drive
Wilson, NC 27893
252-206-1571

Beddingfield High School
4510 Old Stantonsburg Road
Wilson, NC 27893
252-399-7752

Hunt High School
4559 Lamm Road
Wilson, NC 27893
252-294-1655

Dear Parent:

The Wilson Area School Health (W.A.S.H.) centers provide affordable and accessible healthcare to the students of Wilson County Schools. We advocate for the health of children and address a broad range of needs. The goal for the W.A.S.H. centers is to help students succeed in school by promoting healthy lifestyles and providing comprehensive health care to meet the needs of all students. We are located in (4) Wilson County School buildings. The clinic at Forest Hills Middle School is open from 8AM to 4PM. The clinics at Beddingfield, Fike and Hunt High Schools are open 7:30AM to 3:30PM, Monday through Friday. The staff includes a full time Registered Nurse, an Advanced Practice Provider (APP), and an Office Coordinator. We provide immunizations, sports physicals, sick visits, immunizations, well visits and more.

Students with health insurance or Medicaid will be asked to provide information to allow for billing of medical services. Students without insurance coverage will be billed on a sliding fee scale according to their household income and number of people in the home. Please contact our office to discuss income sources. The W.A.S.H. centers can bill most commercial insurances and Medicaid. No sick student with a signed consent form will be turned away for failure to pay or lack of insurance.

If you would like to take advantage of this benefit, please fill out this packet. **All pages need to be completed for your student to be seen in the WASH clinics.**

IMPORTANT: If you have already completed a WASH packet for your child during the last school year, **PLEASE READ THE NEXT TWO STATEMENTS.**

- If there have been **NO CHANGES** to your child's medical history or medical insurance, you do **NOT** need to complete another WASH packet. Sign and date below and return this page to the office at your child's school.

- If there **HAVE BEEN CHANGES** to your child's medical history or medical insurance, please complete a new WASH packet. Turn the packet into the office at your child's school.

If you have any questions or concerns, please call (252) 360-0769. All clinic messages are checked regularly. Please leave only 1 voicemail and we will call you back. We appreciate your interest and support of the W.A.S.H. centers.

Thank you,

W.A.S.H. Staff

Student's Name: _____**DOB:** _____

School: _____ **Grade:** _____

Parent Signature: _____ **DATE:** _____

Wilson Area School Health

STUDENT REGISTRATION FORM

By completing this form, I consent in advance to my child having access to any and all-available services of the Wilson Area School Health program as long as my child remains enrolled in Wilson County Schools. Services include diagnosis and treatment of common illnesses and injuries, sports physicals, immunizations, laboratory testing; preventative health screenings; health education; nutrition counseling and referrals as needed. Services rendered may include remote medical services.

STUDENTS MUST HAVE PARENTAL PERMISSION TO BE SEEN BY WILSON AREA SCHOOL HEALTH.

Student's Last Name	First	Middle Initial	School Attending
Student's Address	City	State	Zip Code

Social Security # **(REQUIRED)**	DOB	Age	Grade	Gender

Race: ☐White ☐Black ☐American Indian ☐Native Alaskan ☐Asian ☐Native Hawaiian ☐Other Pacific Islander

Ethnicity: ☐Hispanic ☐ Non-Hispanic

PARENT/GUARDIAN INFORMATION

Mother/Guardian: _____ _____ _____

Last Name First Name Maiden Name

Address	City	State	Zip Code

Home Phone	Cell/Work	Email

Father/Guardian: _____ _____ _____

Last Name First Name Middle Initial

Address	City	State	Zip Code

Home Phone	Cell/Work	Email

In emergency situations requiring acute care, Wilson Area School Health personnel will contact the Emergency Medical System for transport of the student to the appropriate medical facility for evaluation and treatment. In case of an emergency, who may we contact other than parent or guardian? **PLEASE LIST TWO EMERGENCY CONTACTS, PHONE NUMBER, and RELATIONSHIP.**

1.) Name: _____ Phone #:_____ Relationship:_____

2.) Name: _____ Phone #:_____ Relationship:_____

INSURANCE INFORMATION

Type: ☐ Medicaid ☐ Private Insurance ☐ No Insurance

Insurance Company Name:_____ Policy Number:_____ Group #:_____

Medicaid Type: ☐Ameritas ☐United Health Care ☐Healthy Blue ☐Well Care

Medicaid Number:_____ Subscriber Number:_____

Who is your child's regular or Primary Care Doctor?_____

Name of Preferred Pharmacy/Location/Phone Number:_____

Has your child had a physical in the last year? □ Yes □ No Date of Last Physical: _____

Wilson Area School Health

Student Name:_____

Student DOB: _____Grade:_____

WILSON COUNTY SCHOOL BASED HEALTH CENTER NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU.

Each time you visit a hospital, physician or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used to help you to ensure its accuracy, better understand who, what, when, where, and why others may access your information so you can make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain an accounting of disclosures of your health information
- Request communication of your health information by alternative means or locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization (Wilson County School Based Health Center) is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Examples of Disclosures for Treatment, Payment and Health Operations

- We will use your health information with treatment
- We will use your health information for payment
- We will use your health information for regular health operation

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to them so that they can provide the service we've asked them to do and bill you at your third party payer for services rendered. All standards of confidentiality are rendered under Wilson County Health Department policy.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product/product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information or public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or in the public.

If you have any questions concerning these Privacy Practices you may contact the Privacy Officer at (252)-237-3141.

I have read and understand the Notice of Privacy Practices of the Wilson County School Based Health Center.

Signature:_____ Date:_____

Wilson Area School Health

HIPAA/FERPA

Child's Name:_____ DOB:_____

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. Wilson Area School Health staff will share confidential information only in the following situations:

- with written parental consent
- when it is educationally relevant for a student's academic progress.
- when it is necessary to address a student's potential health care needs.
- to ensure the safety of the student, other students and school personnel
- other situations specified by law

For example, the Wilson Area School Health staff may discuss the student's medication and other health care needs with the appropriate staff member who will administer the student's medication and provide care to the student while the student is in school.

I, the undersigned,

- give permission and consent for my child to have treatment through and by Wilson Area School Health. l understand the nature of this treatment, the way it is provided, and the details and limitations of the telemedicine/remote office visit component of the services offered.
- give permission for Wilson Area School Health to receive information from the school about my child's health history.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website at www.wilsoncountync.gov/departments/health-department or at the Wilson Area School Health centers located at Forest Hills Middle, Beddingfield, Fike and Hunt High Schools.
- agree to release all records related to this treatment to the Primary Care Provider.
- agree that all I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
- as Parent/Legal Guardian of the above student. I:
    - authorize the release of any information necessary to process insurance claims for payment of benefits to Wilson Area School Health/Wilson County Health Department.
    - authorize payment of benefits to Wilson Area School Health/Wilson County Health Department for services rendered.
    - have provided details of all insurance policies that cover my child.

The information above and on the preceding pages is true and complete to the best of my knowledge.

Student Signature: (If older than 18)_____

Parent/Legal Guardian Name: **PRINT**_____

Parent/Legal Guardian Name: **SIGNATURE**_____

Date:_____

Wilson Area School Health

Student Name:_____

Student DOB:_____Grade:_____

ALLERGIES AND MEDICATIONS

Is your child allergic to any medicines or foods? ☐ Yes ☐ No

If yes, please list: _____

Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Has your child ever been hospitalized overnight? ☐ Yes ☐ No

Age/Reason for Hospitalization:_____

AUTHORIZATION & CONSENT FOR REMOTE MEDICAL EXAMS

- I understand that a remote medical exam is an office visit with a Registered Nurse in the room with the student. The Family Nurse Practitioner is at a different location. The visit is conducted via electronic equipment that allows the Nurse Practitioner to deliver healthcare services and communicate with the nurse and the student.
- I understand that this consultation will not be the same as a direct patient/health care provider visit as I will not be in the same room as my health care provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I understand that my health care provider or myself can discontinue the remote exam/visit if it is felt that the video conferencing connections are not adequate for the situation.
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to remote medical exams. As always, your insurance carrier will have access to your medical records for quality review/audit.
- I understand that I will be responsible for any copayments or coinsurances that apply to my remote medical exam.
- I understand that I have the right to withhold or withdraw my consent to the use of remote medical exams in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Wilson Area School Health. As long as this consent is in force (has not been revoked) Wilson Area School Health may provide health services to me electronically without the need for me to sign another consent form.

☐ I **consent** to remote medical exams.

☐ I **do not consent** to remote medical exams.

Signature of Parent or Guardian: _____Date:_____

Wilson Area School Health

IF YOU HAVE COMPLETED THIS HISTORY FORM PREVIOUSLY, YOU ARE NOT REQUIRED TO DO SO AGAIN

NC Child Health Program Initial History Questionnaire

Patient Name:

Date of Birth:

Sex: (Circle) Male Female

Person Who Filled Out Form: Date Filled Out:

Relationship to Patient:

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes

Birth Weight: _____ pounds _____ ounces

Was baby born on time? □ No □Yes ____ weeks

Was the birth □Vaginal □ C-Section If C-Section, Why?

Were there any problems during the pregnancy or at birth?
□No □Yes If yes, explain:

During pregnancy did mom:
Use tobacco? No □ Yes □ Drink alcohol? □ No □Yes
Use drugs or other medications?□ No □Yes What:

Use prenatal vitamins?□ No □Yes When:

Did baby have problems or need to stay in a NICU? □ No □ Yes
If yes, explain:

The initial feeding for the baby was □Formula □ Breast milk
How long did the baby breastfeed?

Did the baby go home with mom? □No □ Yes
If no, explain:

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:

_____

_____

_____

Are there siblings not listed? If so, list names, ages and where they live:

What is your child's living situation?
□ Joint custody □ Single custody □Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?

_____

Tobacco use in family? □ No □Yes Who?_____

CHILD'S HEALTH HISTORY

Has the child ever had:		
Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other: _____	No	Yes
Chicken Pox (Year)	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other:	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone in the **family of the child** (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for			
Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/			
Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History: _____	No	Yes	

Additional Comments: