Your child’s school has a School-Based Health Center! 

School-Based Health Center (SBHC) staff can provide:

- Well child & annual physical exams
- Care for sick visits
- Care for chronic issues
- Counseling services
- Preventative dental care

If your child is home sick you may still bring him/her to their SBHC to be seen.

- ALL students K-12 are eligible. (Pre-K & Headstart are also eligible.)
- ALL students with or without insurance are eligible.
- ALL students with their own family doctor or dentist are eligible. We can serve as your primary care provider or work with your healthcare provider to coordinate care.
- There are no co-pays or deductibles for services provided in school.
- Many parents choose to enroll their children just in case they need it -- no loss of work for parents and students are seen quickly.
Healthy Students Learn BETTER!

North Country Family Health Center
School-Based Health Centers

South Jefferson Central School District
Watertown City School District

Alexandria Central School District*
Copenhagen Central School*
Lowville Academy & Central School District*
South Lewis Central School District*

* Offering Dental Services Only

When school is closed patients can reach us 24/7
Medical ~ 315.782.6400
Dental ~ 315.788.9834

For more information on each School-Based Health Center's contact information visit www.NoCoFamilyHealth.org
Attention Parents

Not Yet Enrolled?
Why Not --- It’s Easy!
ALL students in your child’s school are eligible to enroll in our School-Based Health & Dental Program regardless of income or current healthcare provider. We also provide in-school counseling for students too. Enrollment in the School-Based Health & Dental Program is a great back-up plan in case your child gets ill at school. All School-Based services are provided with no out-of-pocket cost, which means no co-pays or deductibles for parents.

Already Enrolled?
Please take the time to update this packet — including any health history changes from the past year, address changes, or changes in insurance information and be sure to sign the confidentiality and consent form within our enrollment packet.

North Elementary  315.786.1767
Please Note: ALL elementary students can receive medical, dental, and counseling services at North Elementary.
Medical & Counseling services . . . . Monday – Friday 7:30 a.m. – 3:00 p.m.
Dental . . . . Monday 7:30 a.m. – 3:00 p.m.

Ohio Street Elementary  315.779.5611
Dental . . . . Monday 7:30 a.m. – 3:00 p.m.

Case Middle School  315.785.3809
Medical & Counseling services . . . . Monday 7:30 a.m. – 12:00 p.m.
Wednesday & Friday 7:30 a.m. – 3:00 p.m.

Harold T. Wiley School  315.785.3783 for Medical and 315.779.5611 for Dental
Medical & Counseling services . . . . Monday 12:30 p.m. – 3:00 p.m.
Tuesday & Thursday 7:30 a.m. – 3:00 p.m.
Dental . . Monday – Friday 7:30 a.m. – 3:00 p.m.

Watertown High School  315.785.3703
Medical & Counseling services . . . . Monday – Friday 7:30 a.m. – 3:00 p.m.
Students are transported to appointments via school transportation. Parents may bring their son/daughter to their appointment if they are available.
School-Based Health Center
2018-2019 ENROLLMENT FORM

Student’s name: ______________________________________________________________________________________________

(LAST)                                          (FIRST)                                                    (FULL MIDDLE)

Address:______________________________________  DOB: __ / __ /____   Student’s school: ___________________ Grade: _____

Teacher/Homeroom: ______________________  Sex at birth: □ M  □ F  Student’s SS#: _____________________________

RACE: □ White  □ Native Hawaiian  □ Other Pacific Islander
□ Black/African American  □ American Indian/Alaska Native
□ Asian  □ Unreported/Refused to Report

ETHNICITY: □ Hispanic or Latino
□ Non-Hispanic or Non-Latino

Preferred LANGUAGE: ____________________

MEDICAL/DENTAL PROVIDER INFORMATION:

□ My child does not have a regular doctor.
□ My child has a regular doctor. However, I would like to use the School-Based Health Center when necessary. I understand that my child’s healthcare provider will receive reports following visits.

My child’s doctor’s office: ______________________________________ Date of last physical exam: ______________

□ My child does not have a regular dentist.
□ My child does have a regular dentist. However, I would like to use the School-Based Dental Program for my child’s preventative dental care.

My child’s dentist is: ___________________________________________ Date of last dental exam: ______________

□ I DO NOT want my child enrolled in any School-Based Health Program (Please do not complete the information below.)

PARENT/GUARDIAN CONTACT INFORMATION:

Name:________________________________________

Mailing address:________________________________

Best phone number to reach you: __________________

Okay to leave a message or voicemail?    Y      N

Employer:______________________________________

Work phone:___________________________________

Birthdate:_____________________________________

Relationship to student:
□ Father  □ Mother  □ Step-parent  □ Guardian
□ Other:______________________________________

Email:________________________________________

Okay to email in non-emergency situations?    Y      N

Name:________________________________________

Mailing address:________________________________

Best phone number to reach you: __________________

Okay to leave a message or voicemail?    Y      N

Employer:______________________________________

Work phone:___________________________________

Birthdate:_____________________________________

Relationship to student:
□ Father  □ Mother  □ Step-parent  □ Guardian
□ Other:______________________________________

Email:________________________________________

Okay to email in non-emergency situations?    Y      N

Who does the child live with? □ Mother □ Father □ Both parents □ Other: ____________________________

Who may make medical/dental/counseling decisions for this student? □ Mother □ Father □ Both parents □ Other: ______

Student’s mother’s maiden name: _________________________________________________________________

Preferred Pharmacy with address: _________________________________________________________________

Do we have permission to call your child’s emergency contacts which you provided to your child’s school? □ Yes  □ No

North Country Family Health Center, as a Federally Qualified Health Center, must ask you to complete the following:

Where did your child sleep last night? □ In our house/apartment □ In a shelter □ In a car/RV  □ Do not have a place  □ With a friend/relative

What is your household annual income $_____________________ What is the family household size? ______________________________
MEDICAL/DENTAL INSURANCE INFORMATION: Check all that apply. This information is found on your insurance card.

Name of parent/guardian responsible for medical/dental bills: ____________________________ SS#: ____________________________

☐ Primary Medical Insurance: Insurance company name: ____________________________ ID#: ____________________________ Phone: ____________________________

DOB: ______________________________________ ID#: ______________________________________ Phone: ______________________________________

☐ Primary Dental Insurance: Insurance company name: ____________________________ ID#: ____________________________

Policy holder’s information: Name: ____________________________ SS#: ____________________________ Phone: ____________________________

DOB: ______________________________________ Phone: ______________________________________

MEDICAL/DENTAL HISTORY: Has the child had any history of, or conditions related to, any of the following:

☐ ADHD ☐ Cardiac issues ☐ Growth problems ☐ Seizures
☐ Anemia ☐ Chicken Pox ☐ Kidney ☐ Sickle Cell
☐ Asthma ☐ Chronic sinusitis ☐ Latex allergy ☐ Thyroid
☐ Blood disorder ☐ Diabetes ☐ Pneumonia history ☐ Urinary
☐ Cancer ☐ Ear aches ☐ Rheumatic fever ☐ Other

Past surgeries/hospitalizations: ______________________________________________________

Does your child see a healthcare specialist? For example, a cardiologist, dermatologist, or psychiatrist etc. ☐ No ☐ Yes

Name of healthcare specialist: ____________________________ Phone number: ____________________________

Allergies ☐ No ☐ Yes If yes, what is your child allergic to and what is their reaction to the item: ______________________________________

Daily medications? (name and dose): __________________________________________________

Has your child or anyone that lives in your house ever been exposed or had contact with anyone with a positive tuberculosis screen or active Tuberculosis disease? ☐ No ☐ Yes If yes, who: ______________________________________

Who smokes in the household? ______________________________________________________

FAMILY HISTORY: Check any of the following a relative has had. Please include both sides of the family if you can.

<table>
<thead>
<tr>
<th>Allergies/eczema</th>
<th>Mental health disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom</td>
<td>Dad</td>
</tr>
<tr>
<td>Astrhma</td>
<td>Obesity</td>
</tr>
<tr>
<td>Cancer</td>
<td>Stomach/GI problems</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Stroke</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>History unknown</td>
</tr>
<tr>
<td>HIV positive</td>
<td>Other:</td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
</tr>
</tbody>
</table>

Dental Services: Please answer the questions below if you are interested in having your child receive school-based dental services.

Does your child have any developmental delays or problems? ☐ No ☐ Yes, explain: __________________________________________________

Does your child have any dental concerns? ☐ No ☐ Yes, explain: __________________________________________________

Has the child had any problems with dental treatment in the past? ☐ No ☐ Yes, explain: ______________________________________

Has the child ever suffered injuries to the mouth or teeth? ☐ No ☐ Yes, explain: ______________________________________

What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water

☐ Yes, explain: ______________________________________
Counseling Services:

Do you have any concerns about your child’s emotions/behaviors? □ No □ Yes, explain: ____________________________

Would you like your child to be seen by our school-based counseling staff? □ No □ Yes (If yes, one of our counseling staff will be in contact with you.)

CONSENT FOR SCHOOL-BASED HEALTH, DENTAL, & COUNSELING SERVICES 2018-2019

I give my consent for my child, ____________________________, to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Health/Dental and Counseling Programs at a School-Based Health Center or via telemedicine. Services may include, but are not limited to, the following: comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and counseling services if needed. NCFHC has engaged Night Nurse, Inc. as the Center’s after-hours call center; Night Nurse, Inc. records all calls in order to maintain complete and accurate records of care provided to your child. Your signature below serves as consent for calls to or from Night Nurse, Inc. to be recorded. Additionally, I consent to photographs being taken of my child for inclusion in their electronic medical record.

In addition, I give my consent for NCFHC staff to have access to my child’s school health records and copies of my child’s most recent physical exam. I give my permission for the release of my child's reports to his/her healthcare provider and/or the school nurse to coordinate his or her care. I authorize insurance and/or Medicaid payments for services rendered for my dependent directly to NCFHC and the release of medical information necessary to process claims to my insurance carrier. I understand that NCFHC will share patient health information according to state and federal law for treatment, payment, and operations. I understand that every effort will be made to contact me prior to treatment. The staff of NCFHC believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in healthcare decisions. We encourage parents to visit or call the School-Based Health Center at any time. I understand that this consent form will remain in effect as long as my child is enrolled in NCFHC’s SBHC program, unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.

Parent/guardian signature ____________________________ Date: __________________

CONFIDENTIALITY (HIPAA) NOTICE:

North Country Family Health Center (NCFHC) is committed to maintaining the privacy of your child’s protected health information (PHI). Our promise is that your child’s medical records and other PHI will only be released from our practice with a properly executed authorization form from you, the parent, or your representative, except for certain instances. These instances are described in our Notice of Privacy Practices. The Notice is available for you to read in our office or on our website, www.NoCoFamilyHealth.org. The following are possible ways in which we may use or disclose your child’s PHI: These are only examples.

1. When our medical/dental/counseling staff is caring for your child, we will review your child’s medical/dental or counseling history.
2. Our administrative staff may audit your child’s medical/dental/counseling records for completeness and quality assurance.
3. We may need to tell your insurance plan certain information so that we may receive payment for your child’s services.

You have a right to review the Notice before signing this consent. You have the right to ask us to restrict how we use your child’s PHI. We will provide you with a form on which you can make your written request for restrictions. We don’t have to agree to the restriction, but if we do, we are bound by the agreement. We may make changes to the Notice. Upon your request, we will provide you with any revisions.

By signing this form you consent to our use and disclosure of your child’s PHI as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing. You have the right to an accounting of the disclosures of your child’s PHI for other treatment, payment, and healthcare operations. I have been informed and understand my rights regarding the possible ways in which NCFHC may use and disclose my child’s protected health information. In addition, I acknowledge that North Country Family Health Center uses a third party to carry out healthcare functions such as appointment reminders, and after hours telephone triage.

Parent/guardian signature: ____________________________ Date: __________________

(If child is 18 they may sign for themselves)
REQUEST TO OBTAIN INFORMATION: Please complete if your child has another doctor or dentist office.

In order to help the school-based health/dental/counseling staff best meet my child’s healthcare needs, I authorize my child’s Doctor, Dentist, or Counseling offices to release my child’s medical/dental/counseling information. Information to be disclosed may include copies of the most recent physical exam, medical history, immunization records, counseling summaries, copies of dental records, current dental x-rays, and other information necessary to provide medical/dental/counseling treatment.

I agree to allow my child’s personal health/dental/counseling information, as described above, to be sent to North Country Family Health Center (NCFHC). I understand this is voluntary. I understand that NCFHC will protect this information under applicable state and federal privacy regulations.

- I understand that I may see and receive a copy of the information described on this form if I ask for it.
- I understand that I may revoke this permission at any time by notifying my child’s School-Based Health Center in writing. If I do, it won’t have any effect on any actions taken before they receive the revocation.
- I understand that my child’s health/dental/counseling care and payment for my child’s care will not be affected if I do not sign this form.
- This permission form expires one calendar year after the date below.

Parent/guardian signature ___________________________ Date: ________________

| FOR MEDICAL RELEASE: Name and address of child’s Primary Care Provider (PCP) or Practice: |
|____________________________________________________________________________________|

| FOR DENTAL RELEASE: Name and address of child’s Dentist or Dental Group: |
|__________________________________________________________________________|

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th>Child’s birthdate:</th>
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*This information may contain HIV related information. If you experience discrimination because of the release of HIV or other medically related information, you may contact the NY State Division of Human Rights at 212-870-8624. This agency is responsible for protecting your rights.

For Office Use Only: Reviewed by: __________________________ Date: ________________