neighborcare health

SCHOOL-BASED HEALTH CENTERS

IN ELEMENTARY SCHOOLS

Services are available to elementary students at:

- Bailey Gatzert Elementary
- Dearborn Park Elementary
- Highland Park Elementary
- Rising Star Elementary
- Roxhill Elementary
- Vashon Island High School
- West Seattle Elementary

neighborcare.org

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please return completed registration forms to your school's main office or health center.

SCHOOL-BASED HEALTH CENTER
PATIENT REGISTRATION FORM

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Please fully complete this form to help us provide your child with quality care. This consent will remain active from year to year. Please submit a request in writing to withdraw consent for services.

Your student's health is an important part of their academic success. In order to support that success of your student, there is a school-based health center (SBHC), operated by Neighborcare Health, on site available to all students for both in-person and telehealth visits. The SBHC offers all the services of a family doctor and can provide appointments before, during and after school. Even if your student already has a care provider, we can work closely with them, providing a convenient option for medical, dental, and mental health services at school. Neighborcare Health is committed to serving all patients regardless of ability to pay. We hope you take advantage of this resource and look forward to seeing you at school.

Please complete sections 1–3.

1. STUDENT INFORMATION AND DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE NAME	GRADE	PREFERRED FIRST

STUDENT ID NUMBER	DATE OF BIRTH / / MONTH DATE YEAR	BIRTH SEX ❑ Male ❑ Female	LEGAL SEX ❑ Male ❑ Female ❑ Nonbinary

GENDER IDENTITY	❑ Female ❑ Male ❑ Questioning	❑ Transgender Male to Female ❑ Transgender Female to Male ❑ Nonbinary/Gender Queer		❑ Other _____ ❑ Choose not to disclose
SEXUAL ORIENTATION	❑ Straight ❑ Gay	❑ Lesbian ❑ Queer	❑ Bisexual ❑ Pansexual	❑ Other:_____ ❑ Choose not to disclose
PRONOUN	❑ She, Her, Hers ❑ He, Him, His		❑ They, Them, Theirs ❑ Other:	❑ Choose not to disclose
ARE YOU HISPANIC OR HISPANIC-LATINO?	❑ Yes, Hispanic or Latino		❑ Not Hispanic or Latino	❑ Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ More than one race	❑ Asian ❑ Other Pacific Islander ❑ Declined to identify		❑ Black/African American ❑ White

WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?		DO YOU NEED AN INTERPRETER?	❑ Yes ❑ No

MAILING ADDRESS	APT

CITY	STATE	ZIP

PARENT/GUARDIAN'S PHONE	STUDENT PHONE
___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

PARENT/GUARDIAN'S E-MAIL ADDRESS	STUDENT E-MAIL ADDRESS

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME	DATE OF BIRTH / /	SEX ❑ Male ❑ Female

RELATIONSHIP TO STUDENT

This form continues on reverse. Please complete all sections. ➲

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SCHOOL-BASED HEALTH CENTER
PATIENT REGISTRATION FORM

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Continued from reverse.

2. INSURANCE

DO YOU HAVE INSURANCE?	❑ Yes ❑ No			
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE		EFFECTIVE DATE	
	GROUP PLAN NUMBER		MEMBER ID #	
	SUBSCRIBER/POLICY HOLDER NAME		SUBSCRIBER DATE OF BIRTH	

3. ADDITIONAL QUESTIONS (Answer for patient or, if patient is a minor, please answer for legal guardian.)

YEARLY OR MONTHLY INCOME	What is your household's annual (yearly) gross income?	$	If easier to calculate, what is your household's monthly income?	$
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return:			
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	❑ Not Homeless ❑ Doubling Up ❑ Other ❑ Permanent Supportive Housing ❑ Public Housing ❑ Shelter ❑ Street ❑ Transitional			
MIGRANT/SEASONAL WORK STATUS	At any point in the past two years, has seasonal or migrant farm work been your or you family's main source of income?		❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work	
HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (Mark all that apply)	❑ Friends or family ❑ Other non-Neighborcare provider ❑ Other community group or program ❑ Ads (billboard, bus, newspaper)	❑ Insurance ❑ Convenient location/close to home ❑ Social media (Facebook, Twitter, Instagram) ❑ School	❑ Online search (Google) ❑ Other	

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SCHOOL-BASED HEALTH CENTER
CONSENT FOR HEALTH SERVICES

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Neighborcare Health's school-based health centers are located in Seattle Public Schools and the Vashon Island School District. Neighborcare Health must have signed consent from a parent or legal guardian before providing services, except in situations where federal or state laws allow the student to access treatment without parent/guardian consent. Students do not need to be registered at the health center to receive services from the school nurse.

First Name	Middle Initial	Last Name	Date of Birth
			/ /

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to this clinic is currently correct and understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical, Mental Health, and Dental staff of the above named clinic to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my child's health problems. I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by licensed Mental Health Therapist or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical/Dental Director. The assignment and release authorizes Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care provider who have rendered services to me. I agree to pay all charges that are not paid in full by assigned insurance.

NOTICE OF PRIVACY PRACTICES: I understand that Neighborcare Health's Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information is available to me at the location(s) my child receives their health care services and on the Neighborcare Health website at https://neighborcare.org/patients/rights-and-responsibilities/

Student Signature: *(Required for 13 and older)*	Date: / /
Parent/Guardian Signature:	Date: / /
Name of Legally Responsible Guardian (Print):	Relationship:

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages students to involve their parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent."

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SCHOOL-BASED HEALTH CENTER
HEALTH HISTORY FORM

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Please complete this form to help us provide your child with quality care. Your child will be invited to the health center for a health screening to review their weight, height, blood pressure and immunization history, and complete a health risk assessment. The health center will contact you about any recommendations for supporting your child's health and readiness to learn. Additional consent from a parent/guardian is required before giving any vaccines. Please contact the health center if your child has a health issue and needs an appointment.

STUDENT	First Name	Last Name	Date of Birth / /
Printed Name of Person Completing Form		Relationship to Student (if not self)	Date Form Completed / /

QUESTIONS ABOUT YOUR CHILD:

❑ Yes ❑ No Has your child had a well child check up or full physical in the past year?

❑ Yes ❑ No Has your child seen a dentist in the past year?

❑ Yes ❑ No Does the student have any medication, food, or other allergies? If yes, what?

(Describe):

❑ Yes ❑ No Does your child take any medications? (Include vitamins and over-the-counter medications.)

Medication	Dosage	Reason

❑ Yes ❑ No Does the student have any medical problems or mental health concerns?

If yes, what?

❑ Yes ❑ No Has the student ever had any surgery, serious illness, or injury?

(Describe):

❑ Yes ❑ No Do you have other concerns about your child's well being? (e.g.: too much worry, stress, depression, anxiety, etc.)

(Describe):

FAMILY HEALTH HISTORY (*Check all that apply)*

Has anyone in the student's family had the following? *If yes, check box and write in the family member (e.g. mom, dad's mom...) next to condition.*

❑ Asthma _____
❑ Diabetes _____
❑ Heart problems/stroke _____
❑ Mental health problems _____
❑ Alcohol or chemical use _____
❑ Cancer _____
❑ Seizures _____
❑ High blood pressure _____
❑ High cholesterol _____
❑ Died before age 50 _____
❑ Other: _____

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SCHOOL-BASED HEALTH CENTER
DENTAL SCREENING CONSENT

neighborcare health

SCHOOL:	CLASSROOM #:	MRN: (For Administrative Use)

DEAR PARENT OR GUARDIAN:

We are offering dental screenings in your child's school to inform you about your child's dental health. The screenings have **no out of pocket cost to you.**

If you agree to have us screen your child:

- Dental screenings will resume when students return for in-person learning.
- We will be happy to give you information to make a dental appointment, or make an appointment for you, if you need a dental provider.
- We will send you a copy of your child's results. This information may be shared with your child's school.
- We may leave a message on your phone if we need to contact you about your child's dental needs.

WHAT IS A DENTAL SCREENING?

A Neighborcare Health dental provider will look at your child's teeth and make a **visual evaluation.**

They will apply a **fluoride varnish** which is a protective coating that is painted on teeth to help prevent new cavities and to help stop cavities that have already started.

A dental screening **does NOT take the place of a complete dental exam** by your child's dentist.

Parents or Guardians, please fill out the information below and sign the bottom of the form.

NAME OF STUDENT:			
FIRST NAME	MI	LAST NAME	DATE OF BIRTH / /
GENDER OF STUDENT: ❑ Male ❑ Female ❑ X		GRADE:	

NAME OF PARENT/GUARDIAN:			
FIRST	MI	LAST	DATE OF BIRTH / /
ADDRESS:		CITY:	ZIP:
PHONE #:			

Do you prefer to be contacted in a language other than English?	❑ No ❑ Yes	If yes, what language?
How would you like to receive your child's dental evaluation results?	❑ Please give them to my child at school to take home. ❑ Please mail them to the address listed above.	
When did your child last see a dentist?	❑ Less than 6 months ago ❑ Less than 2 years ago ❑ Less than 1 year ago ❑ More than 2 years ago ❑ Never	
Does your child have a regular dentist?	❑ No ❑ Yes	If yes, where?
Would you like help finding a dentist for your child?	❑ No ❑ Yes	

This program is without cost to you, but your health insurance company may be billed for services. Please complete the insurance section of this form to ensure we have the most current information. Public insurance plans generally cover the entire fee of the screening. If any costs are not covered by insurance, they will be covered by grants. No out-of-pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's two yearly dental exams.

PLEASE LIST YOUR APPLE HEALTH OR OTHER DENTAL INSURANCE INFORMATION BELOW:					
DENTAL INSURANCE NAME:					
SUBSCRIBER NAME:					
RELATIONSHIP:		SUBSCRIBER GENDER:		SUBSCRIBER DOB:	/ /

BY SIGNING THIS FORM YOU AGREE TO TWO DENTAL SCREENINGS AND FLUORIDE VARNISHES.

SIGNATURE OF PARENT OR GUARDIAN	DATE