



Siskiyou Community Health Center

STUDENT HEALTH CENTER

EVERGREEN ELEMENTARY SCHOOL

520 W River Street
Cave Junction, OR 97523
Main Office: (541) 592-6491
Fax: (541) 592-6489

ALL STUDENTS WHO PLAN TO USE THE EVERGREEN ELEMENTARY SCHOOL STUDENT HEALTH CENTER FOR THE 2018/2019 SCHOOL YEAR MUST COMPLETE AND RETURN THE EVERGREEN HEALTH CENTER PACKET.

What is a School-Based Student Health Center?

A School-Based Health Center is much more than the traditional school nurse's office. It is a medical facility located in the school that offers many health and medical services like your doctor's office (see list below). We do not replace your primary doctor and all of our services are provided at Evergreen Elementary School. The Student Health Centers at Evergreen Elementary, Lorna Byrne Middle School and Illinois Valley High School are operated by Siskiyou Community Health Center through an agreement with the Three Rivers School District.

Who works at the Evergreen Elementary School Student Health Center?

Our staff includes a Physician Assistant (PA) who can treat most health problems and prescribe medications, and a registered nurse (RN). Brief mental health counseling and/or referral to mental health/drug and alcohol services are also available. All staff are supervised by and have support of the Siskiyou Community Health Center physicians and medical director.

What services are offered?

We can take care of most of your student's health care needs at the Evergreen Elementary School Student Health Center. If there is an emergency or service we do not provide, we contact 911 or will make a referral to another health care provider. When the health center is not open or staff is unavailable, school personnel will follow Evergreen Elementary School guidelines for all emergency situations.

- ❖ Wellness and how to maintain it for a lifetime
- ❖ Physical examinations, routine and sports
- ❖ Mental health services and counseling
- ❖ Referrals to other health care providers
- ❖ Immunizations and flu shot
- ❖ Assessment of health strengths and challenges
- ❖ Nutrition education and weight management
- ❖ Diagnosis and treatment of minor illness
- ❖ Dental screening
- ❖ Vision and blood pressure screening
- ❖ Tests such as anemia, diabetes and infection

What about costs and billing?

Siskiyou Community School Based Health Center wants to provide health care for all students who need it. Many of our services are provided at no charge; however, there are some services that we provide

that require an exam and medical action that **may** result in a charge. Examples of some of these services include:

Sore Throat	Pink eye
Ear pain	Abdominal pain
Cough	Foreign body in eye
UTI symptoms	Follow-up visits
Sprain/fracture	Well Child checks
Head injury	Immunizations

If a visit does result in a charge, we will bill your insurance for you, including the Oregon Health Plan. We also offer a sliding discount program which is based on your family size and income. Anyone can apply for this program even if you have insurance. Additional information and an application are included in this packet. We encourage all families to complete an application. An office visit summary will be sent home after a billable service is provided.

What about parental consent?

At the health center we require parental/guardian signed consent for a student to use our services.* We support and encourage parental involvement in decisions about your student's health care.

What about confidentiality?

Our health services and records are private and confidential. Health records will not become a part of your student's school record and will only be used by health center staff unless you give us written permission to share information.

Like other health care providers, the Evergreen Elementary School Student Health Center follows the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA regulates how medical information may be used and disclosed and how you can get access to this information. We are required to give you a copy of our Notice of Privacy Practices and have you sign the Acknowledgment and Consent which is included in the packet.

What about appointments?

Appointments are encouraged whenever possible. A parent may call and make an appointment or your student is welcome to come by and schedule an appointment. Hours will be posted on the clinic door and in the school bulletin.

Evergreen Elementary School esta dispuesto a ayudar a sus estudiantes hispano hablantes ya sus padres con traducciones cuando sea necesario. Los programas de esta escuela están abiertos a todos los estudiantes sin discriminar por razones de sexo, raza, ni impedimento físico.

Evergreen Elementary School can arrange to help Spanish speaking students and their parents with translation when necessary. The programs of this school are open to all students without discrimination for reasons of sex, race or inability to pay.

**Oregon State Law (ORS 109.610, ORS 109.640) requires a parent or guardian's signature for medical treatment for students less than 15 years of age, with the exception of treatment for sexually transmitted diseases and for birth control information and services. Oregon State Law (ORS 109.675) states that a student 14 years and older may obtain mental health and chemical dependency treatment without parental knowledge or consent.*



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Phone: (541) 592-6491 Fax: (541) 592-6489

INFORMED CONSENT TO TREAT

Student Name: Last	First	Middle Initial	Date of Birth
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Parent/Guardian Name	Relationship to Student	Home Phone
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All services are provided at Evergreen Elementary School Health Center and by signing yes on this consent you **do not** replace your regular doctor. Services that are provided to students may be billable. However, service will not be withheld for inability to pay. We will contact parent/guardian by phone prior to administering over-the-counter medications to elementary students. However, if your child has a fever greater than 102° F, or is having a severe allergic reaction, or severe breathing difficulties, we will give immediate treatment to your child following our protocols. This usually means generic Tylenol to reduce fever, generic Benadryl for allergic reactions, or Albuterol for breathing emergencies. Parent/guardian will be contacted by phone or letter if **prescription** medications are indicated.

Students will be encouraged to discuss visits with their parents; however, confidentiality will be provided at the student's request. Oregon State Law (ORS 109.610, ORS 109.640, and ORS 109.675) requires strict confidentiality regarding evaluation, diagnosis and/or treatment for sexually transmitted diseases, sexuality issues, pregnancy testing or mental health services. The Evergreen Elementary School Student Health Center will not dispense birth control supplies or provide abortion referrals.

YES I consent to health care services offered by the Evergreen Elementary School Student Health Center for the above named student. I understand that this consent is valid as long as my student is enrolled in an Illinois Valley elementary school program unless terminated in writing.

NO I do *not* give my consent to services offered.

The American Academy of Pediatrics recommends children have a comprehensive physical exam performed every year. If you are interested in scheduling a well child exam for your child, please indicate by checking the box below:

YES I would like for my child to have a comprehensive physical scheduled at Evergreen Elementary School Based Health Center. Please call me to schedule.

NO I do NOT want my child to have a comprehensive physical exam this year.

Parent/Guardian Signature

Date

PLEASE COMPLETE THE FAMILY HEALTH HISTORY





Siskiyou Community Health Center

STUDENT HEALTH CENTER

FAMILY HEALTH HISTORY

Student Name: _____ DOB: _____ Today's Date: _____

Medicine Allergies: _____

STUDENT MEDICAL HISTORY		FAMILY MEDICAL HISTORY						
Yes	No	Has this student had any:	Yes	No	Has any family member died suddenly at less than 50 years of age of causes other than an accident?			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness such as diabetes, seizures, cancer, hepatitis, mono?	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Surgeries?	Signify health conditions which occur in the family. Include natural parents, brothers, sisters, and grandparents.					
<input type="checkbox"/>	<input type="checkbox"/>	Urinary, kidney problems, undescended testicles?						
<input type="checkbox"/>	<input type="checkbox"/>	Missing or damaged organs (eye, kidney, testicle)?						
<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?						
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with exercise? Wheezing? Cough?						
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with or without exercise?						
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches, anemia, bleeding or blood clot problems?						
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, asthma, severe bee sting reaction?						
<input type="checkbox"/>	<input type="checkbox"/>	Learning disorders or slowed development?						
<input type="checkbox"/>	<input type="checkbox"/>	Vision or hearing problems?						
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox? If yes, what year? _____						
		Does this student:				Yes	No	Who?
<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?				<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces, plates?				<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	Take any medication on a regular basis? (prescription or over-the-counter)				<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect _____
		Is there a history of:	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders _____			
<input type="checkbox"/>	<input type="checkbox"/>	Concussion, loss of consciousness, convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Breast Problems _____			
<input type="checkbox"/>	<input type="checkbox"/>	Injuries to neck, knees, ankles?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____			
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones, joint injury, disease or dislocation?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____			
		Has student had:	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems _____			
<input type="checkbox"/>	<input type="checkbox"/>	2nd measles, mumps & rubella vaccine (MMR)?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches _____			
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B vaccine series?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Attacks _____			
<input type="checkbox"/>	<input type="checkbox"/>	Year of last tetanus vaccine? _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____			
			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Obesity _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Seizures _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____			
			<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

Date of last dental exam: _____ Date of last well child exam/sports physical: _____

Use the space below to explain any of the **YES** answers or to provide any additional information:

Parent/Guardian Signature _____

Date _____



Siskiyou Community Health Center

STUDENT REGISTRATION FOR SCHOOL-BASED HEALTH CENTER

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager

Date: _____

STUDENT INFORMATION

Last: _____ First: _____ MI: _____ Jr. Sr. III

Other Names Known By: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: Male Female

RESPONSIBLE PARTY NAME

Last: _____ First: _____ MI: _____ Jr. Sr. III

Relationship to Patient: _____ Social Security #: _____ - _____ - _____

Gender: Male Female Date of Birth: ____/____/____

Mailing Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Street Address (if different from above): _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

May we leave a message? Yes No **May we leave a message?** Yes No

Where does your child usually go for health care? _____

INSURANCE

Private Insurance Oregon Health Plan (OHP) Self Pay

PRIMARY INSURANCE

If you have insurance (including OHP) please fill out this section.

Company: _____

Policy/ID#: _____

Policy Holder's Name: _____

Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE

As a courtesy to our patients, we bill most secondary insurances.

Company: _____

Policy/ID#: _____

Policy Holder's Name: _____

Date of Birth: _____

Relationship to Patient: _____

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, the following statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

<p>STUDENT STATUS</p> <p><input type="checkbox"/> Full-Time</p> <p><input type="checkbox"/> Part-Time</p> <p><input type="checkbox"/> Not Applicable</p>	<p>STUDENT PRIMARY RACE</p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Caucasian (White)</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> Other</p>	<p>Gross Annual Household Income</p> <p>\$ _____</p> <p><i>*Annual income amount is gathered for grant funding requirements.</i></p>
<p>PRIMARY LANGUAGE</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Sign Language</p> <p><input type="checkbox"/> Other _____</p>	<p>ETHNICITY</p> <p><input type="checkbox"/> Hispanic/Latino</p> <p><input type="checkbox"/> Non-Hispanic</p>	<p>HOMELESS</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>Do you need an interpreter?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>		<p>_____ # Members in Family</p>

PRIVACY PRACTICES – ACKNOWLEDGEMENT

I understand that the Student Health Center, operated by Siskiyou Community Health Center (referred to below as “This Practice”) will use and disclose health information about me which may include information both created and received by This Practice, may be in the form of written notice or electronic records or spoken words.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for insurance coverage and submit claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for qualify, cost-effective health care.

I acknowledge that this program complies with the HIPAA Privacy Security Act and a copy is available online at This Practice’s website at www.siskiyouhealthcenter.com.

I have the right to revoke this authorization at any time, provided that I do so in writing and to the extent that This Practice has already used or disclosed the information based on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 36 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent/Guardian Signature: _____ **Date:** _____

The mission of Siskiyou Community Health Center is to identify and provide care for the primary health needs of our community in a professional and compassionate manner.

Siskiyou Community Health Center is a private, not-for-profit equal opportunity provider and employer.



Siskiyou Community Health Center

SCHOOL-BASED HEALTH CENTER/DENTAL PREVENTION

Sliding Discount Program Enrollment Form

Siskiyou Community Health Center wants to provide quality health care to our patients, regardless of their ability to pay. This Sliding Discount Program is based solely on family size and income in relation to the federal poverty level for services provided by our School-Based Health Centers (SBHCs) and Dental Outreach Programs.

Enrollment in this program is valid for the school year. To continue being considered for this program, a new Enrollment Form must be completed each school year. If eligible, your child will be able to receive medical care services at our SBHCs, as well as dental education and prevention service provided through our Kids Smile Dental Prevention Program, free of charge.

Student's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____

List household members. This includes yourself, spouse and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separately.

Name (First and Last)	Relationship	Date of Birth	Gross Monthly Income
_____	SELF	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

Signature (Parent/Guardian) _____ Date _____

Print Name (Parent/Guardian) _____

FOR OFFICE USE ONLY

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: \$ _____

Qualifies for SBHC/Dental Outreach Slide: Yes No

Siskiyou Community Health Center Signature

Date



SISKIYOU COMMUNITY HEALTH CENTER
Parent Questionnaire Health Assessment: K-4th grade

Student name _____ Date of Birth _____

Please help us to provide the best care to your child and family by filling out the following questionnaire. This information will be kept private in your student's medical record and not shared with the school. Any questions you don't feel comfortable answering, please feel free to leave blank. If you would prefer not to fill it out, please check the box below. Thank you for your help.

I decline to fill out the following questionnaire.

1. Does your child make healthy choices by eating fruits, vegetables daily? **Yes No** How much? _____
2. Do they drink milk or eat other dairy daily? **Yes No** How much? _____
3. Do you put limits on your child's intake of soda and junk food? **Yes No**
How much are they allowed? _____
4. Does your child engage in physical activity of at least an hour daily? **Yes No** _____
5. Does your child spend less than 2 hours a day watching TV, playing video games or other screen time? **Yes No**
6. Does your child practice good dental hygiene by brushing twice a day and flossing daily? **Yes No**
7. Does your child have a dentist? **Yes No** If so, when was their last visit? _____
8. At home is your child required to follow good safety and injury protection practices like always using a seatbelt when riding in a car, and wearing helmets for bike riding or other activities? **Yes No** _____
9. If there is a gun in the home is it kept in a locked and secure location? **Yes No**
10. Is your child aware of gun safety rules? **Yes No**
11. Do you feel your child enjoys school and is doing well with peers and schoolwork? **Yes No**
Comments? _____
12. Does your family enjoy at least one meal a day at the table together? **Yes No**
13. If a family member smokes at the child's home, is it done inside or outside? _____
14. Do you and your child feel safe at your home and in your neighborhood? **Yes No**
Comments? _____
15. Do you have any concerns about an adult having inappropriate physical contact with your child? **Yes No**
Comments? _____
16. Do you have any concerns about your child's emotions and well being? **Yes No**
Comments? _____
17. Does your family experience any of the following? *Please check all that apply*

<input type="checkbox"/> Recent move or change in housing	<input type="checkbox"/> Violence in the home	<input type="checkbox"/> Separation/Divorce
<input type="checkbox"/> Job loss or Job change	<input type="checkbox"/> Lack of medical care	<input type="checkbox"/> Household member dealing with substance abuse
<input type="checkbox"/> Death	<input type="checkbox"/> Lack or shortage of food	

18. Do you have any other concerns about your child? _____



DENTAL PREVENTION PROGRAM Consent to Treat



With parental permission, your child may participate in the **KIDS SMILE DENTAL PREVENTION PROGRAM** and will receive dental education and prevention services provided at their school or daycare. This service is not necessary for children already receiving regular dental treatment. This dental screening and education is open to **ALL** children regardless of income or insurance status. We will bill your insurance company if the information is provided. **If your child is uninsured**, he/she may be eligible to receive these services for free under our Sliding Discount Program. To be considered for this discount, please complete the attached application. Remember to sign and date the form.

If you would like your child to receive these services, please fill out this consent form and return it to your child's school or day care center.

Name of Student _____ Birth date ____/____/____ Sex (M/F) ____
 School _____ Grade _____ Teacher _____
 Does your child have any medical problems or allergies? (Please explain) _____

Does your child currently take a daily prescription fluoride tablet? No Yes
 Please circle the number of months since the last time your child saw a dentist:
 3-6 months 6-9 months Over 12 months Never Seen

Dentist's Name _____

Do you have dental insurance: No Yes (Please circle type of insurance below)
 OHP—**Advantage** OHP—**Capitol** OHP—**MODA** OHP—**Open Card** OHP—**Willamette**

Insurance Patient ID #: _____

Private Dental Insurance: _____ Patient ID #: _____

Primary Holder of Insurance: _____

I authorize the following for my child: (Please mark the boxes below)

- Dental health screening**
- Fluoride varnish application** (As need indicates)
- Dental sealants on molar(s)**
(A thin preventative coating applied into chewing surface grooves to keep bacteria out.)

If you have any questions please contact:
 Amy Tripp, BSDH at (541) 295-8070



If you said **YES** to screening, flouride and/or sealants, your signature indicates:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any personal health information, between the dental sealant staff, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or Dental Care Organization of record. I acknowledge that this program complies with the **HIPAA Privacy Security Act** and a copy is available online at our website at www.siskiyouhealthcenter.com.

You have a right to revoke this authorization at any time, provided that you do so in writing and to the extent that we have already used or disclosed the information based on this authorization.

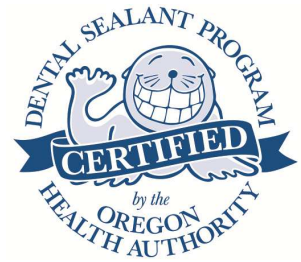
Unless revoked earlier or otherwise indicated, this authorization will expire 36 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent /Guardian Signature: _____ Date _____

****PLEASE COMPLETE ALL INFORMATION ON BOTH SIDES OF THIS FORM****



"Kids Smile" Dental Prevention Program



- The **"Kids Smile" Dental Prevention Program** is an opportunity for your student to receive dental preventative treatments which may include an oral health screening, oral hygiene education, fluoride application and sealants. School sealant programs can reduce cavities by 50%.²
- These services are available at **no cost to you**; please see the details on the next page.
- Each participating child will receive **a report of services completed**.
- **More than half of all children have a cavity by age nine.**¹ Dental disease, if left untreated, may cause pain, infection, loss of teeth and can lead to serious health risk.
- **1 in 5 children have untreated decay.**¹
- **Fluoride varnish applications 2 to 4 times per year** can reduce cavities in permanent teeth by 43% and in baby teeth by 37%.³
- **Sealants** are the most effective cavity preventing measure. **A child 6-9 years old child will benefit most** from this thin protective coating applied on molars.
- **All students are invited. It's important to complete both the *Consent to Treat and Slide Discount Application forms for your child to receive these services.***

¹ Oregon Health Authority. (2012). *Smile Survey*. Retrieved from <https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/Oral-Health-Publications.aspx>

² Community Preventive Services Task Force. (2013). *The Community Guide*. Retrieved from https://www.thecommunityguide.org/sites/default/files/assets/Oral-Health-Caries-School-based-Sealants_0.pdf

³ Cochrane Collaboration. (2013). *Fluoride varnishes for preventing dental caries in children and adolescents*. Retrieved from http://www.cochrane.org/CD002279/ORAL_fluoride-varnishes-for-preventing-dental-caries-in-children-and-adolescents

If you have any questions please call:

Kids Smile Dental Prevention Program
Amy Tripp, BSDH, Expanded Practice Dental Hygienist
(541) 295-8070

