STUDENT HEALTH CENTER

ILLINOIS VALLEY HIGH SCHOOL

625 East River Street
Cave Junction, OR 97523
Main Office: (541) 592-3749
Fax: (541) 592-4449

ALL STUDENTS WHO PLAN TO USE THE ILLINOIS VALLEY HIGH SCHOOL STUDENT HEALTH CENTER FOR THE 2018/2019 SCHOOL YEAR MUST COMPLETE AND RETURN THE IVHS 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. We offer 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 Illinois Valley High 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 Illinois Valley High School Student Health Center?
Our staff includes a Physician Assistant (PA) and a Family Nurse Practitioner (FNP) 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 Illinois Valley High 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 Illinois Valley High 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 Illinois Valley High 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.

Illinois Valley High 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.

Illinois Valley High 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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INFORMED CONSENT TO TREAT

Student Name: Last	**First**	**Middle Initial**	**Date of Birth**

Parent/Guardian Name	**Relationship to Student**	**Home Phone**

All services are provided at IVHS Health Center and by signing yes on this consent form you **do not** replace your regular doctor. Services that are provided to students may be billable. However, services will not be withheld for inability to pay. Unless you ask us in writing **not** to, we will go ahead and treat children with minor ailments with over-the-counter medications. This usually means cough drops for sore throats or coughs, generic Tylenol to reduce fever or headaches, generic Ibuprofen for headaches or cramps, generic Benadryl for allergic reactions. If your child has a breathing problem, we may also use an Albuterol inhaler according to our protocol. If you have any questions about our medication policies, please contact the Student Health Center at Illinois Valley High School. An attempt will be made to contact the parent/guardian 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 Illinois Valley High School Student Health Center will not dispense birth control supplies or provide abortion referrals.

☐ **YES** **I consent to health care services offered by the Illinois Valley High 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 middle or high school program.**

☐ **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 Illinois Valley High 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

Yes	No	Has this student had any:
☐	☐	Chronic or recurrent illness such as diabetes, seizures, cancer, hepatitis, mono?
☐	☐	Hospitalization/Surgeries?
☐	☐	Urinary, kidney problems, undescended testicles?
☐	☐	Missing or damaged organs (eye, kidney, testicle)?
☐	☐	Problems with heart or blood pressure?
☐	☐	Chest pain with exercise? Wheezing? Cough?
☐	☐	Dizziness or fainting with or without exercise?
☐	☐	Frequent headaches, anemia, bleeding or blood clot problems?
☐	☐	Allergies, asthma, severe bee sting reaction?
☐	☐	Learning disorders or slowed development?
☐	☐	Vision or hearing problems?
☐	☐	Chicken pox? If yes, what year? __________
		Does this student:
☐	☐	Wear eyeglasses or contact lenses?
☐	☐	Wear dental bridges, braces, plates?
☐	☐	Take any medication on a regular basis? (prescription or over-the-counter)
		Is there a history of:
☐	☐	Concussion, loss of consciousness, convulsions?
☐	☐	Injuries to neck, knees, ankles?
☐	☐	Broken bones, joint injury, disease or dislocation?
		Has student had:
☐	☐	2nd measles, mumps & rubella vaccine (MMR)?
☐	☐	Hepatitis B vaccine series?
		Year of last tetanus vaccine? ____________________

FAMILY MEDICAL HISTORY

Yes	No	
☐	☐	Has any family member died suddenly at less than 50 years of age of causes other than an accident?

Signify health conditions which occur in the family. Include natural parents, brothers, sisters, and grandparents.

Yes	No		Who?
☐	☐	Allergies	__________
☐	☐	Asthma	__________
☐	☐	Birth Defect	__________
☐	☐	Bleeding Disorders	__________
☐	☐	Breast Problems	__________
☐	☐	Cancer	__________
☐	☐	Diabetes	__________
☐	☐	Gallbladder Problems	__________
☐	☐	Headaches	__________
☐	☐	Heart Disease/Heart Attacks	__________
☐	☐	Hepatitis	__________
☐	☐	High Blood Pressure	__________
☐	☐	Kidney Disease	__________
☐	☐	Obesity	__________
☐	☐	Sickle Cell Anemia	__________
☐	☐	Seizures	__________
☐	☐	Stroke	__________
☐	☐	Thyroid Disease	__________
☐	☐	Tuberculosis	__________
☐	☐	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**

Form 207 041218

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: (_____)________________________________
May we leave a message? Yes No

Cell Phone: (_____)________________________________
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.

STUDENT STATUS
- ☐ Full-Time
- ☐ Part-Time
- ☐ Not Applicable

PRIMARY LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other _______________

Do you need an interpreter?
- ☐ Yes
- ☐ No

STUDENT PRIMARY RACE
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian (White)
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

HOMELESS
- ☐ Yes
- ☐ No

Gross Annual Household Income

$_________________

**Annual income amount is gathered for grant funding requirements.*

______ # Members in Family

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**

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*****

Form 509 083016

“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