RHG SCHOOL BASED HEALTH CENTER STUDENT REGISTRATION CONSENT FORM

STUDENT INFORMATION			SCHOOL:
Name (Last, First, Middle):	Date of Birth:	Gender: ☐ Male ☐ Female	Grade & Teacher:
Ethnicity ☐ Hispanic ☐ Non-Hispanic	Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Mexican American Indian ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other:	Primary Language Spoken if not English:	

PARENT/COURT ORDERED LEGAL GUARDIAN INFORMATION (*If you are an emancipated student, please indicate here*)			
Name:	Date of Birth:	Relationship to Student:	Does student live with you? ☐ Yes ☐ No
Street Address:	City, State, Zip Code		
Primary Phone Number: ☐ Cell ☐ Home Landline	Work or Day Phone # and Extension:	Other Phone Number:	Email Address:

ADDITIONAL PARENT/COURT ORDERED LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION			
Additional Parent/Guardian Name (if applicable):	Date of Birth:	Relationship to Student:	Does student live with you? ☐ Yes ☐ No
Street Address:	City, State, Zip Code		
Primary Phone Number: ☐ Cell ☐ Home Landline	Work or Day Phone # and Extension:	Other Phone Number:	Email Address:
In Case of Emergency Contact Name:	Relationship to Student:	Phone #:	Other Phone #:

HOUSEHOLD INFORMATION	
Is a parent/guardian employed in agriculture: ☐ Yes ☐ No	**If yes,** what type of position do you hold? ☐ Grower ☐ Migrant Farmworker (travel to seek work) ☐ Year-Round Farmworker ☐ Seasonal Farmworker (live here; agricultural work during the harvest season)
What is your housing/living situation? ☐ Living in my own home/apartment (own or rent) ☐ Living with relatives/friends ☐ Experiencing homelessness ☐ Living in a shelter/transitional housing	Who does the child live with most of the time?

STUDENT MEDICAL HISTORY

Does your child have any of the following conditions or health concerns? (check all that apply):

☐ Allergies to medication _____
_____
☐ Allergies (other than medicine, such as bee stings, peanuts, etc.)
_____
☐ Asthma Date of last asthma attack: _____
☐ Seizures Date of last seizure: _____
☐ Hospitalizations Dates and Details: _____
☐ Operations Dates and Details: _____
☐ Anemia
☐ Diabetes
☐ Sickle Cell

☐ Vision problems
☐ Hearing problems
☐ Heart problems
☐ Kidney problems
☐ Bleeding disorders
☐ Orthopedic (bone/joint) problems
☐ Anxiety/depression
☐ Autism
☐ ADHD
☐ Developmental delays

☐ Chronic diseases in siblings: _____
_____
☐ Behavioral issues: _____
_____
☐ Frequent absences or disruption from daily activity
☐ Other _____
_____
_____
_____

Daily Medications:	Reason for Taking:	How long has your child taken this medication?	What is your preferred pharmacy?

Has there been any change in your child's health during the past year? ☐ Yes ☐ No If Yes, please explain here:

Is there anything else you would like for the school based health center to know about your child?

Does the child have a regular doctor or other medical provider ☐ Yes ☐ No Name of provider or clinic: _____

MEDICAL INSURANCE INFORMATION

Is the student covered by medical insurance? ☐ Yes ☐ No

Is the student covered by Medicaid or NC Health Choice? ☐ Yes ☐ No ☐ Pending
If Yes, Medicaid or NC Health Choice ID#:_____
If No, Would you like information about Medicaid or NC Health Choice? ☐ Yes ☐ No

Applying for the Rural Health Group Sliding Fee Program: If your child is uninsured or you have a high insurance deductible plan, we would like to help by determining if you would qualify for our "sliding fee" program. If you are interested to learn more, one of our case managers will reach out with more information. ☐ Yes, I am interested in learning more about the sliding fee program.
No student will be denied health services based on their parent/legal guardian/or emancipated student's inability to pay

PRIMARY MEDICAL INSURANCE/NC MEDICAID/NC HEALTH CHOICE			
Name of Insurance Company	Name of Policyholder	Date of Birth of Policyholder	Relationship to Student
Insurance ID Number (Policy #)	Group Number	Insurance Co. Phone #	
What is your co-pay?	Social Security # (for insurance purposes only)		

SECONDARY MEDICAL INSURANCE (if applicable)			
Name of Insurance Company	Name of Policyholder	Date of Birth of Policyholder	Relationship to Student
Insurance ID Number (Policy #)	Group Number	Insurance Co. Phone #	
What is your co-pay?	Social Security # (for insurance purposes only)		

Student Name:	Student Date of Birth: (p.2)

DENTAL INFORMATION

Rural Health Group's School Based Health Center provides preventive dental services at your child's school.

Has your child seen a dentist? ☐ Yes ☐ No If YES, is your child currently seeing a dentist? ☐ Yes ☐ No
If YES, when was their last dental visit? _____

What was the name of the dental office or dentist visited? _____

Would you like for your child's dental home (primary dentist) to be Rural Health Group (RHG)? ☐ Yes ☐ No

Dental Preventive Services we will provide include:

- Dental examination
- Radiographs (x-rays)
- Prophylaxis (cleaning)
- Sealant application
- Fluoride application
- Oral hygiene instructions

All dental services will be provided by licensed dentists and hygienists.

Do you give your consent to the School Based Health Center to provide preventive dental services for your child?

☐ No, I do not give my consent to the SBHC to provide preventive dental services to my child.

☐ Yes, I give my consent to the SBHC to provide preventive dental services to my child.

Rural Health Group's primary dental office is located at 2064 NC Hwy 125, Roanoke Rapids, NC 27870 and we can be contacted at 252-536-5880 if you have any questions.

DENTAL INSURANCE INFORMATION

Is the student covered by dental insurance? ☐ Yes ☐ No

Name of Insurance Company	Name of Policyholder	Date of Birth of Policyholder	Relationship to Student

Insurance ID Number (Policy #)	Group Number	Insurance Co. Phone #

What is your co-pay?	Social Security # (for insurance purposes only)

BEHAVIORAL HEALTH INFORMATION

Rural Health Group's School Based Health Center provides behavioral health (mental health) services in your child's school. Are you interested in behavioral health services for your child? ☐ Yes ☐ No

OTHER

Would you like to hear more about the other services we can provide your family, such as other RHG services, our Sliding Fee Discount Program, or direction to community resources? ☐ Yes ☐ No

KIPP PRIDE High School students have unique schedules. Which period(s) would the student prefer to see the clinical team, if needed?
Periods _____ Timeframes: _____

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES

Available upon request and on our website www.rhgnc.com you will find a **Notice of Privacy Practices** that details the way we keep your child's medical record confidential, and what rights you have to access that medical record. You will also find a form listing Student and Parent Rights & Responsibilities. We are required by Federal Law to provide you with this information and we ask that you read the Notice of Privacy Practices and Rights & Responsibilities for both you and your child. Please call (252) 692-4289 and speak to our RHG Privacy Officer if you have any questions. Thank you for your cooperation in our effort to comply with this law.

CONSENT

I, the undersigned,

- Give permission and consent for my child to have treatment through and by the School Based Health Center. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- Give permission for the School Based Health Center to receive information from the school about my child's health history.
- Give permission for my child to receive treatment via telehealth solutions with primary care providers at RHG clinics.
- Give permission for RHG SBHC to communicate with your child's primary care provider about your child's health.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website www.rhgnc.org).
- Acknowledge that under NC law (G.S. § 90.21.5), minors have the right to consent to services for the prevention, diagnosis, and treatment of venereal disease and other diseases that must be reported to the state; pregnancy; abuse of controlled substances or alcohol; and emotional disturbance.
- Acknowledge that this consent form remains in effect until the student leaves their current school.
- Acknowledge that I may withdraw my consent at any time via letter from the parent, guardian, adult or emancipated student.
- Agree that 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 the Parent/Guardian of the above student, I:
  - o Authorize the release of any information necessary to process insurance claims for payment of benefits to Rural Health Group, Inc. School Based Health Centers.
  - o Authorize payment of benefits to Rural Health Group, Inc. School Based Health Centers for services rendered.
  - o Have provided details of all insurance policies that cover my child.

Please sign the following declaration: By signing this form, I consent to my child having access to any or all available services of Rural Health Group, Inc. School Based Health Centers as long as my child remains enrolled in school. Services include: diagnosis and treatment of common illnesses and injuries, preventive health screenings, health education, behavioral health services, preventive dental services, and referrals as needed. The information on the form is true and complete to the best of my knowledge. If I am an adult student 18 years old or older or legally emancipated, I consent to the above services by completing this form.

Parent/Guardian/Emancipated Student Signature:_____

Printed: _____ Date:_____

If you would like to speak with one of our medical providers to discuss your child's health or concerns, please contact RHG at (252) 536-5000 and we will be happy to assist you!

RHG Pediatrics Office: 2064 NC Hwy 125, Roanoke Rapids, NC 27870: (252) 536-5000
RHG Primary Dental Office: 2064 NC Hwy 125, Roanoke Rapids, NC 27870: (252) 536-5880

The School Based Health Center can be reached at (252) 308-0577 and sbhc@rhgnc.org. The SBHC offers medical, dental, behavioral health, and case management services.

Please complete this form and give to your child's school or email it to SBHC@RHGNC.ORG.