RHS SCHOOL-BASED HEALTH SERVICES
CHILD ENROLLMENT FORM
Questions? 803-219-1926

Rural Health Services, Inc. (RHS) has partnered with your child's school to provide healthcare and dental services during school hours through our school-based health team. Services are provided to all students regardless of their ability to pay or if they are insured. **Parents will never receive a bill but private insurance or Medicaid will be billed.**

The information must be filled out in ink by a parent or legal guardian. If your child already has a dentist or doctor, you should keep going to that dentist or doctor.

MEDICAL SERVICES INCLUDE:
Well-child exams, medical screening (blood), & head-to-toe examination, treatment, and nutritional counseling.

DENTAL SERVICES INCLUDE:
Exam, x-rays, cleanings, sealants, and Fluoride. Additional parental consent is required for operative work (fillings).

BEHAVIORAL HEALTH SERVICES INCLUDE:
Screening to identify behaviors that hinder success in school, home, or community. Counseling and/or intervention as needed will be provided with parental consent.

I WANT MY CHILD TO BE SEEN BY (CHECK SERVICES THAT APPLY): ☐ Medical Staff Only ☐ Dental Staff Only ☐ Both Medical & Dental ☐ Behavioral Health (Ridge Spring Elem. & CIL only)

CHILD'S PERSONAL INFORMATION

School: ______ Grade: ______ Teacher: ______

First Name: ______ Last Name: ______ Parent/Guardian Email: ______

Date of Birth : __ __ / __ __ / __ __ (M M D D Y Y) Age: ______ Social Security : ____ - ____ - ____

Address : ______ City: ______ State: ______ Zip: ______

Emergency Contact: ______ Phone: ____ - ____ - ____ Relationship: ______

Primary Doctor: ______ Dentist: ______

HELP US GET TO KNOW YOUR CHILD BETTER

Gender at birth : ☐ Male ☐ Female Gender Identification : ______

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check All That Apply) : ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Prefer not to say ☐ Multi-races ______

Preferred Language: ☐ English ☐ Spanish ☐ Other ______ Translator needed? ☐ Yes ☐ No

Housing: ☐ Single Family Home ☐ Homeless ☐ Doubling up ☐ Shelter ☐ Transitional Housing ☐ Other/Prefer not to say

INSURANCE INFORMATION (REQUIRED)

As the Responsible Party, **I understand that my dental or medical insurance carrier or payer of my benefits will be billed for services rendered. Medicaid or private insurance is accepted as payment in full for service(s).** If your child's insurance changes during the year make sure that we get an updated copy of your insurance card and/or updated insurance information.

☐ **CHILD HAS MEDICAID**

Medicaid Provider ______ Medicaid #: ______

☐ **CHILD HAS PRIVATE INSURANCE:**

Insurance Company Name: ______ Phone # of Company: ____ - ____ - ____

Policy Holder's Name: ______ Employer: ______

Policy Holder's ID or SS# ______ Group#: ______

Date of Birth : __ __ / __ __ / __ __ (M M D D Y Y) Phone # of Policy Holder ____ - ____ - ____

☐ **CHILD HAS SEPARATE DENTAL INSURANCE:**

Insurance Company Name: ______ Phone # of Company: ____ - ____ - ____

Policy Holder's Name: ______ Employer: ______

Policy Holder's ID or SS# ______ Group#: ______

Date of Birth : __ __ / __ __ / __ __ (M M D D Y Y) Phone # of Policy Holder ____ - ____ - ____

☐ **CHILD IS UNINSURED (NO INSURANCE):**
CALL 803-679-4243 to speak to our state-wide marketplace navigator or certified insurance application counselors.

FAMILY INFORMATION

Parent/ Guardian: ____________________

Address : ____________________ City: __________ State: ______ Zip: ________

Home Phone: ____ - ____ - ______ Cell Phone: ____ - ____ - ______ Email: ____________________

Preferred Pharmacy: ____________________ Family Yearly Income Level: $ __________

Address/Phone # of Pharmacy ____________________ ____ - ____ - ____

Date of the last time your child saw a dentist of doctor?

Date of Dentist : M M / D D / Y Y Date of Doctor: M M / D D / Y Y

Would you like any other adult to be able to give permission to treat your child? This would also allow the dental and medical team to talk about your child's health, treatment, and recommendations with this adult. If yes, please provide:

Full Name: ____________________ Phone #: ____ - ____ - ______ Relationship to child: __________

MEDICAL HISTORY

Write Yes (Y) or No (N) on the line provided beside the question.

Has the student had surgery in the past? If yes, EXPLAIN why: ____________________

Are any of the child's teeth causing pain? __________

Does the child smoke, use tobacco and/or recreational drugs? __________

Is the student pregnant or possibly pregnant? __________

Have there been any changes in the student's health in the past year? EXPLAIN: ____________________

Has the student ever been hospitalized overnight? If so, list dates and the reason: ____________________

Has the student had any serious or sport-related injuries? __________

Does the student have any allergies (food, medication, anesthetics, latex, etc.)? If so, list them: ____________________

Has your child been in contact with the AIDS virus or have they tested positive for HIV? __________

Does your child take any daily medications, including over-the-counter or inhalers? If yes, explain: ____________________

Check all that apply for your child:

- ☐ High or low blood pressure
- ☐ Ulcer or Acid Reflux
- ☐ Heart Transplant
- ☐ Pacemaker
- ☐ Recent Blood Transfusion
- ☐ Sinus Problems (Hay Fever)
- ☐ Stroke or mini-stroke
- ☐ Congenital Heart Disease
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Epilepsy and/or Seizure
- ☐ Cancer/Radiation/Chemo
- ☐ Bacterial Endocarditis
- ☐ Cortisone Steroid Treatment
- ☐ Heart conditions including murmur
- ☐ Nervous Disorder/Behavioral Problems
- ☐ Learning Disability or Special Needs
- ☐ Anemia (incl. sickle cell anemia) Type: __________
- ☐ Artificial or prosthetic heart valve, stent, or graph
- ☐ Sexually Transmitted Infection (Disease). EXPLAIN: ____________________
- ☐ Asthma, Breathing Problems or lung disorder, EXPLAIN: ____________________
- ☐ Kidney Trouble, EXPLAIN: ____________________
- ☐ Tuberculosis, MRSA, or any other infectious disease. EXPLAIN: ____________________
- ☐ Asthma, Breathing Problems or lung disorder, EXPLAIN: ____________________
- ☐ Liver disease, Hepatitis, jaundice, bleeding disorder or history of Leukemia. EXPLAIN: ____________________
- ☐ Does your child have any other medical problems not listed? If yes, please list and explain: ____________________

AUTHORIZATION

1. I authorize the School-Based Dental Staff to perform diagnostic procedures and treatment as may be necessary for proper dental care, including (but not limited to) exams, x-rays, cleanings, and sealants.
2. I authorize the RHS School-Based Medical Staff to perform a well-child checkup including medical examination, screening, treatment and/or behavioral health screening.
3. I authorize the RHS School-Base Medical Staff to immunize my child and/or administer flu shot if needed.
4. I authorize the RHS School-Based Behavioral Health Staff to conduct screening to identify behaviors that hinder success in school, home, or community (Ridge Spring Elem. & CIL only).
5. I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
6. I authorize the release of any information regarding my child's healthcare, advice, and treatment to another dentist, doctor, or school nurse/official
7. I authorize payment of insurance benefits directly to Rural Health Services.
8. I attest to the accuracy of the information provided in this form. I understand that it is my responsibility to inform the RHS staff of any changes in my child's insurance and medical status on or before the next appointment.
9. I understand that services may be provided in person or virtually via telehealth.

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization of PHI Disclosure
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights can be found at www.HHS.gov. By returning this form to my child's school, I acknowledge my understanding of my rights concerning HIPAA. I also am aware that treatment plans that may contain health information may be sent home with my child for my review. I understand that I may revoke this authorization at any time by contacting RHS at the contact information listed below.

Parent or Guardian Signature: ____________________ Date: M M / D D / Y Y