Cincinnati Health Department

School-Based Health Center Enrollment Packet
For students at NON-SBHC schools

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: ______________________________**DOB:** ___/___/____ **Gender: M/F Trans: MTF/FTM or Non-Binary**

Child's Social Security #: ________-__________-___________ Medical Card/Insurance ID: ______________________________

☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ No Insurance ☐ OTHER ____________

DENTAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

EYE CENTER SERVICES:

☐ **YES,** I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO**, I do not wish for my child to receive **VISION SERVICES**

MEDICAL HEALTH CARE SERVICES: Available at the following sites: Aiken, AWL, Children's Home of Cinti, JP Parker, Mt. Airy, Oyler, Riverview, Roberts, Roll Hill, Ethel Taylor, Taft HS, West Hi/Dater HS, and Withrow HS)

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate).
****Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.***

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)

______________________________ ______________________________ ______________

Parent / Guardian Signature (or patient if 18 or older) **Parent/Guardian Name** (PRINT) **DATE**

Phone (best) ______________________ Phone #2________________________ Phone #3________________________

____ __________ ______________

ADDRESS STREET APT CITY STATE ZIP

I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). **Consent in effect until terminated in writing** by Parent/Guardian.

STUDENT/PATIENT'S NAME: ________________________________ DOB: ___/____/____

To provide health services for your child we need the following information:

Parent/Guardian Name: ______________________________________ Parent/Guardian's Date of Birth: ____________

Relationship to Child: _________________________ Parent/Guardian's Social Security No.: __________________

Address: ____ City/State/ZIP: _________________________

Emergency Contact Person: ___________________________________ Phone Number: ________________________

Your Child's Health History

- Do you have a **Primary Care Doctor**? ☐ YES ☐ NO
  Doctor Name/Clinic: ____________________________________ Phone #: ______________ Fax #:________________
  Date of last complete yearly physical examination (head to toe): ________________________

- Do you have a **Primary Dentist?** ☐ YES ☐ NO
  Dentist Name/Clinic: ____________________________________ Phone #: ______________ Fax #:________________
  Date of last routine dental check-up: ________________________

- Do you have a **Primary Eye Doctor?** ☐ YES ☐ NO
  Eye Doctor Name: ______________________________________ Phone #: ______________ Fax #:________________
  Date of last routine vision exam: ________________________

- Do you have a **Preferred Pharmacy?** ☐ YES ☐ NO
  Preferred **Pharmacy**: ____________________________________ Phone #: ______________ Fax #:________________

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

****<u>SPECIAL NOTE</u>: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you <u>must</u> complete a CPS Administration of Medication form****

Has your child had any operations, serious injuries, or hospitalizations? ☐ No ☐ Yes
Please provide reason and dates: ____

Has your child ever been pregnant? ☐ No ☐ Yes If *Yes*, how many living children has your child given birth to: _________

Has your child been a victim of abuse? ☐ No ☐ Yes

Has anything bad, scary or sad happened to your family? ☐ No ☐ Yes
Please explain: ____

School Concerns: Explain any YES answers on the line provided.

Is your child in a special class (Special Ed / IEP / 504 Plan)? ☐ YES ☐ NO ____________________________
Has your child repeated a grade? ☐ YES ☐ NO ____________________________
Does your child get into trouble often at school? ☐ YES ☐ NO ____________________________
What are your child's grades? ______________________ ***Is this a change?*** ☐YES ☐ NO

(Please continue to the next page)

PREPARING STUDENTS
FOR LIFE

Health History Update - 2023-2024

Please fill out and return to the school nurse or office. Thank you.
Ohio law requires that a current Health History form be on file for every student.

_______________________ _______________________ _____/_____________
Student's Name Date of Birth Grade/Homeroom

_______________________ _______________________ _______________________
Doctor's Name Phone Number Last checkup or visit

_______________________ _______________________ _______________________
Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (Circle one: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Insurance Provider's Name____________________

____None

Any history of the following problems? (Circle Y for YES or N for NO)

History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N
Life Threatening Allergy to:____________________ EpiPen prescribed	Y N Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems ______________	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N
Developmental Problems ___________	Y N	
Cancer – type __________________	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History For Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/Concussion? When___________	Y N Y N	Y N
Frequent Stomachaches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease – type ____________	Y N	Y N
Kidney Disease – type ___________	Y N	Y N
Learning Problems ____________	Y N	Y N
Prematurity or Birth Weight under 5 lb.	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothaches/Dental Problems	Y N	Y N
Problems with Vision Wears Glasses	Y N Y N	Y N
Surgery? What type?___________	Y N	

Tuberculosis (TB) Risk Assessment:

Is your child in contact with any of the following people: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

For your child, please circle Yes or No below, and explain any Yes answers.
Diagnosed or treated for TB? ___No ___Yes ____
Immigration from another country? ___No ___Yes ____
Traveled to another country? ___No ___Yes ____
Ever been in jail or in 2020 (Juvenile Detention Center)? ___No

Student's Name____

Has your child received the COVID-19 Vaccine? ___No ___Yes Dates: ____

Please list any **CURRENT** health problems or conditions your child has (may be same as above): ____________
____

Please list any allergies (include **food, medications**, environmental, seasonal, etc.): _______________________

Please list any dietary restrictions (medical or non-medical) ____

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number: _____________
____

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): _________________________________
____

SPECIAL NOTE: If your child must take any medications at school, including emergency medications (such as an inhaler or Epi Pen), you must fill out a CPS Administration of Medication form (available at the school).
Has your student had any operations, serious injuries or overnight hospital stays? No ___Yes ____; please explain:
____

Has your child ever been pregnant? No ___Yes ____; please explain:
____

Has your child ever been a victim of abuse? No ___Yes ____; please explain:
____

Has anything bad, scary or sad happened to your family? No ___Yes ____; please explain:
____

PREPARING STUDENTS
FOR LIFE

School Concerns

Is your child in a special education class? No ___Yes ____; please explain: ________________________________

Has your child repeated a grade? No ___Yes ____; details: ____

Does your child get into trouble at school? No ___Yes ____; details: _____________________________________

What are your child's grades on the report card? ________________________________

Any changes recently in grades? No ___ Yes ___

Name of Parent/Guardian ____ Date ____________

How can we reach you during school hours? Cell:_______________ Work_____________ Other______________

Emergency Medical Authorization Form

Fill out this form and return it to your child's school.

Student's Name: ______________________________ ID #: _________ Homeroom: ______ Birth Date: _________

School: ____ Grade: _______ Year: _________

Student's Address: ____ Apt.: ________ Phone: ____________

City: ______________________________ State: _________ Zip: _______________

Purpose — To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Parent / Guardian Name:____ Daytime Phone:____________________

Parent / Guardian Name: ____ Daytime Phone:____________________

Other's Name: ____ Daytime Phone:____________________

Name of Relative or Child-care Provider: ____

Relationship: ____ Daytime Phone:____________________

Address: ____ Zip: ___________

PART I or PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for following medical-care providers and local hospital to be called:

Physician: ____Phone: ____________________

Dentist: ____Phone: ____________________

Medical Specialist:____Phone: ____________________

Local Hospital: ______________________________ Emergency Room Phone: ____________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

____

____

Date: _______________ Signature of Parent/Guardian: ____

Address: ____ Zip: _________

PART II: REFUSAL TO GRANT CONSENT I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take the following action:

____

____

Date: _________ Signature of Parent/Guardian: ____

Address: ____Zip: __________

PLEASE REVIEW THE FOLLOWING INFORMATION

Program Description

School-Based Health Center

Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at one of school-based dental centers located at Academy of World Languages, Withrow High School, Western Hills High School, Oyler School, Crest Smiles Shoppe, or other CHD Health Centers. If you have any questions or need help with the application, please call the School Health Program 357-2809 or contact your school nurse

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow 30 days for completion of insurance or disability forms..
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-357-2787.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.
- Dates of service regarding completed dental, vision and medical care (ie. Immunizations, annual well-child check and asthma care) may be shared with your child's school if you agree and sign the Authorization form provided with this consent.

I have the right to receive or review a copy of the Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices:

⇨ I have received or reviewed a copy (signature and date) ____

I do not want a copy (signature and date) ____

I authorize the SBHC to call my home or cell phone number and leave a message with an adult that answers the telephone or on the voicemail pertaining to my child's medical care, including laboratory results.

Consent for Nitrous Oxide Sedation

Patient Name:_________________________

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections (“Novocaine”). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be “asleep” and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

____

Signature (Parent/Guardian) Phone Number Date

city of CINCINNATI
HEALTH DEPARTMENT
We know **health** matters

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

Facts for consideration:

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

Benefits of SDF treatment:

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs patients that may require sedation for extensive dental care.

Risks related to SDF:

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidently applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.

Patient Name: ____ Date of Birth:______________

Patient/Guardian Signature:______________________________ Date:_____________________

CHD Dental Staff Signature: _____________________________ Date:_____________________