Rockingham County Student Health Centers

McMichael ♦ Morehead ♦ Reidsville ♦ Rockingham

Parent or Guardian,

Enclosed is a permission form for your child to receive services at the Student Health Centers. You **must** return a signed permission form in order for your child to receive services. The Student Health Center is open each day school is in session. Hours of operation are posted at each center. When the Student Health Center is not open and a student is ill and needs medical/mental health services students with Carolina Access or any other insurance should receive 24 hour coverage from their primary care provider (PCP) in a non-emergency situation. The emergency room should only be used in emergencies. At any time, if your child receives mental health services from the Student Health Center and experiences a crisis, please call (336) 612-3741. Students with private health insurance, Health Choice, or Medicaid coverage should provide information to allow for billing for services. If insurance doesn't cover a charge the parent/guardian will be financially responsible for charges. Students without insurance coverage will be billed on a sliding fee scale according to their income and number of supported members in the household. No student that has a signed consent form will be turned away for failure to pay or lack of insurance.

Student Health Center staff will encourage your child to discuss all health problems with you. You will be notified of your child's visits to the Health Centers according to the following guidelines:

1. Parent/guardian notified as soon as possible by phone or in person:
   emergencies and urgent visits requiring immediate attention or outside referral.

2. Parent/guardian notified same day by phone or in person:
   illnesses requiring antibiotics.

3. Parent/guardian notified by phone or note sent home with student:
   non-urgent outside referrals or x-rays.

4. Parent/guardian notified verbally by student:
   physical exams, rechecks and minor infections.

5. Parent/guardian notified only with student's consent or in a life-threatening situation:
   counseling and confidential visits (emotional disturbance, STD, substance abuse, and pregnancy). This is required by North Carolina law in General Statutes 90-21.4 and 90-21.5. A copy of this law may be viewed at our web site. This law applies whether your child is seen in the Student Health Center, by your family doctor, at a hospital, or a public health department.

Please return the attached forms to the Student Health Center at your child's school.

Our main goal is to keep your child healthy so that he or she may successfully complete high school. If you have any questions please feel free to contact me at (336) 623-9711, ext. 2341, or visit our website at **http://rcshc.weebly.com/**.

Sincerely,

Cathy DeMason

Catherine DeMason
Director of Student Health

117 East Kings Highway ♦ Eden, North Carolina 27288 ♦ (336) 623-9711

Rockingham County Student Health Centers

I, _____, parent/legal guardian of_____
request that the Student Health Center (SHC) staff and health care providers* designated by them provide or arrange medical services to meet the needs of my child. These services include:

On-site:

1. Medical evaluation, including history, physical examination, and routine office laboratory tests. This includes Health Check exams.
2. Treatment of injuries and illnesses.
3. Counseling, assessment, consultation, and referral to appropriate services.
4. Substance abuse prevention and intervention.
5. Pregnancy prevention education.
6. Social work services.
7. Gynecological services and education, (services do not include condom or other birth control distribution or abortion counseling).
8. Selected prescription and non-prescription medications.
9. Nutritional services.
10. Mental Health Counseling and Education (group and/or individual).
11. Immunizations
12. Chronic disease monitoring and treatment in collaboration with student's Primary Care Provider.

Referrals:

13. Dental Services.
14. X-rays.
15. Prenatal and obstetric care.
16. Additional laboratory services that are not available on-site.
17. Medical sub-specialty consultations.
18. Selected prescription and non-prescription medications that are not available through SHC.

*Health care providers may include staff or contracted professionals including physicians, physician assistants, nurse practitioners, registered nurses, lab technicians, nursing assistants, social workers, health educators, nutritionists, counselors, and therapists, all of whom are licensed, certified, or registered and have professional credentials to perform specified assessments and treatments.

I understand that North Carolina Statue 582 protects a minor's right to receive services relating to sexually-transmitted diseases, pregnancy, drug abuse, and emotional disturbance without parental consent. I understand that medical providers are not allowed to notify me about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I understand that this law not only applies to the SHC but also to all private doctor's offices and hospitals. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so.

I further understand that the SHC will make every effort to encourage my child to discuss problems and services with me.

For services not designated as confidential, I understand that I will be kept informed and will be asked to authorize my child's treatments other than non-medicinal or over the counter treatments and a yearly physical exam. In the event my child requires urgent medical care and I cannot be reached, I request that my child be allowed to authorize his own care with the understanding that I will be contacted as soon as possible.

The SHC has my permission to share information to coordinate my child's care with UNC Rockingham Health Care and Annie Penn Hospital or with private providers. I give permission for the Rockingham County Student Health Centers and Rockingham County School System to share information on immunizations. I give permission for information in medical records to be used for billing third party payers such as Medicaid or other insurance and for program management and evaluation purposes on a strictly confidential basis in accordance with law and acceptable medical practice. I also authorize to have insurance payments sent directly to Rockingham County Student Health Centers. In order to protect the confidentiality of the services provided through the SHC, I request that the privacy of my child's records be maintained and that they be kept confidential and not be released, except as authorized above, to me or anyone else without my child's consent.

Has your child had a physical exam in the last 3 years? Yes _____ No _____ Date:_____
Where was the physical done?_____
May we verify with your provider the date the physical was completed? Yes_____ No_____

WE MUST HAVE YOUR SIGNATURE & INSURANCE INFORMATION BEFORE YOUR CHILD CAN RECEIVE SERVICES

Parent/Legal Guardian's Signature_____Date_____

Student's Last Name_____First_____Date of Birth_____

Rockingham County Student Health Centers

Student's Last Name_____ First_____ Middle_____

Date of Birth_____ Soc. Sec#_____ School_____ Grade_____

Sex:(circle) Male Female Ethnicity:(circle) Hispanic Non-Hispanic Student School Email:_____

Race:(circle) Am. Indian/Alaska Native Asian Black Hispanic Nat. Hawaiian/Other Pacific Islander Other Race White

Mailing Address_____ City_____ State_____ Zip_____

Primary Phone#_____ Parent Email_____

Mother/Guardian:_____ Phone#_____ Cell Phone#_____

Father/Guardian:_____ Phone#_____ Cell Phone#_____

Who does the child live with most of the time?_____

In Case of Emergency, please tell us a Local Friend or Relative (not living at same address) whom we could contact.

Name_____ Relationship_____ Phone#_____

Person Responsible for the Bill:_____

Is the Patient covered by insurance?☐ YES ☐ NO Does your child receive free or reduced lunch at school?☐ YES ☐ NO

If you would like to apply for free or reduced services at the Student Health Center, please list:
Family Annual (yearly) Income:_____ Family Size (how many people in your immediate family):_____

Primary Insurance: PLEASE ATTACH COPY OF INSURANCE CARD
Name of Insurance Company:_____
ID Number:_____ Group Number:_____
Name of Subscriber:_____ DOB:_____ SS#:_____
Patient's Relationship to Subscriber: SELF CHILD OTHER:_____

Student's Doctor_____ Office Phone#_____
Student's Dentist_____ Office Phone#_____ Date of last visit_____
Preferred Pharmacy_____ City_____

Does your child have any of the following conditions or other health concerns:

☐Allergies, (such as bee stings or peanuts) Please list _____

☐Asthma – Date of last asthma attack_____ ☐Seizures – Date of last seizure_____

☐Vision Problems ☐Hearing Problems ☐Sickle Cell Anemia ☐Bleeding Disorders

☐Heart Problems–Please List _____ ☐Behavior Problems–Please Explain_____

☐Orthopedic (bone or joint) Problems ☐Anxiety/Depression ☐Diseases in Siblings

☐Operations/Hospitalizations–List (Dates/Details)_____

***If you checked ANY of the above conditions, please explain:**_____

Is your child on any medications? ☐No ☐Yes – Please List _____

Is your child allergic to any medications? ☐No ☐Yes – Please List _____

Other health concerns:_____

CONFIDENTIAL

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Student Name:_____ Date: _____

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fights with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits the doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Take things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Score _____ (for office staff use)

Does your child have any emotional or behavioral problems for which she or he needs help? ☐ N ☐ Y

Are there any services that you would like your child to receive for these problems? ☐ N ☐ Y

If yes, what services? _____

Thank you for completing this questionnaire. Please return to the Student Health Center.