Dear Parent and Guardians,

Community Care of West Virginia (CCWV) is pleased to offer school-based health services in your child’s school during the school day. Schedules will be posted at each school with dates and times. Licensed healthcare providers are available at your school to provide expanded medical (treatment for illnesses or injuries, and physicals), and behavioral health (individual) on-site and/or by referral. School-based health services work in conjunction with care provided by your child’s regular primary care provider (PCP). If your child does not have a PCP, we can be their PCP.

All children enrolled in the school-based health services program are eligible to receive services regardless of insurance status. CCWV accepts most insurance plans. Coverage and costs for these services depend upon your insurance/Medicaid coverage. If you have no insurance, please ask our staff about enrolling your child in the WV CHIP program, Medicaid, or the CCWV sliding fee program. Parents are welcome to accompany their student for scheduled appointments at the health center. For unscheduled acute care visits, we will attempt to notify the parents if the student needs to be seen by a provider. If the parent cannot be reached, the student will be treated and further attempts to contact the parent after the visit will occur. Parents may access their child’s medical records or communicate with the provider through the patient portal at www.ccwv.org.

Parents are encouraged to actively participate in their child’s health care. You are welcome to call or stop by the health center any time. We hope that we can help your child have a healthy and successful school year. Our goal is to keep students from missing unnecessary class-time and parents from missing unnecessary work time to take care of their medical needs.

All parts of this registration/enrollment form must be completed, signed, and returned to your child’s school along with a copy of your insurance card, if applicable, before your child can receive services.

Enrollment Form may be downloaded and filled out on-line at: www.ccwv.org

CONTACT INFORMATION:
Community Care of West Virginia
37 West Main Street
Buckhannon, WV 26201
1-855-678-2298
SCHOOL-BASED HEALTH CENTER (SBHC) ENROLLMENT

Student’s Name: ________________________________ Date of Birth: ______________

Student Social Security Number: ____________________________

Male/ Female (Please circle one)

Ethnicity: 

□ Hispanic  □ Unknown  □ Hawaiian  □ Black  □ White

□ Non-Hispanic  □ American Indian  □ Asian  □ Alaskan Indian

Grade: ___________ School: ____________________________

Parent/Guardian Information:

Parent/Guardian Name: ________________________________

Address: ___________ ___________ __________________________

Home Phone: ________________ Work: ________________ Cell: ______________________

Email Address: ____________________________ Consent to Text: □ Yes □ No

Number in Household: _______  Number of Siblings in other schools: ______________________

If we are unable to reach you, who should we call?

Name: ________________________________  Phone: __________________________

Relationship to the student: ________________________________

Insurance Information: (please attach copy of insurance/medical cards)

□ Student has no insurance  □ Student has insurance  □ Student has a medical card

Insurance/Medical Card Name: ____________________________

Phone Number on Card: ____________________________

Address on Card: ____________________________

Identification Number: ____________________________

Group Number: ____________________________

If insurance coverage exists, please list the policy holder's name, date of birth, and Social Security number.

Name: ________________________________  Date of Birth: ____________________________

Social Security Number: ________________________________

Does your child have any medication, food, or latex allergies: _______ If yes, please list below:

________________________________________________________________________________

________________________________________________________________________________

Does your child take any medications: _______ If yes, please list name and dosage below:

________________________________________________________________________________

________________________________________________________________________________

Has your child had any surgeries? _______ If yes, please detail type of surgery below:

________________________________________________________________________________

________________________________________________________________________________

Please list any medical conditions your child has (example: asthma, allergies, ADHD) ________________

________________________________________________________________________________

________________________________________________________________________________
Please check the boxes below to acknowledge your agreement:

☐ I give permission for my child to be treated by the school-based health staff (Community Care of West Virginia, Inc.). A brief history will be conducted during initial visit with provider.

☐ I understand services may include medical services.

☐ I understand services may include behavioral health services.

☐ I understand services may include dental services (in certain locations)

☐ I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient’s health. I will contact SBHC staff if any of the child’s medical history or information changes.

☐ I agree that messages can be left for me on the telephone number provided in the parent/guardian information section of this form.

☐ I have reviewed CCWV’s Notice of Privacy Practices at www.ccwv.org

☐ Release of Information and Payment Authorization: I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to Community Care of West Virginia, Inc. for services provided.

☐ Consent and Acknowledgment of Privacy Practices: I consent to the use and disclosure of my protected health information by CCWV to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by CCWV may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with State and Federal law which may require that I provide specific authorization. I understand that information regarding how CCWV will use and disclose my information can be found in CCWV’s Notice of Privacy Practices. I understand that this consent is effective as long as CCWV maintains my protected health information.

☐ Authorization for Exchange of Health and Education Information: I hereby authorize CCWV to exchange health and education records (including immunization records) with my child’s school district for the purpose of providing care and treatment to my child, if applicable.

☐ Authorization for Exchange of Health Information: I hereby authorize CCWV to exchange health records (including immunization records) with my child’s Primary Care Provider (PCP) for the purpose of continuity of care and treatment of my child.

This authorization is valid until I revoke this authorization. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records if received by the school district may not be protected by the HIPAA Privacy Rules, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I agree that a copy of this authorization is as valid as the original.

By signing below, I understand and acknowledge the following:

1) I have read and the understand this consent: and,

2) I have reviewed CCWV’s Notice of Privacy Practices currently in effect.

3) I accept responsibility for payment of charges incurred for any services rendered to me or my dependents.

Parent/Guardian Signature_________________________________________ Date____________________________

☐ Please check if you would like a copy of our Notice of Privacy Practices emailed to you.
Student’s Name: ______________________________________________ Date of Birth: ______________

Primary Care Provider: _______________________ Phone Number: ______________________

Dentist: ______________________ Phone Number: ______________________
    Date of last dental exam__________________________

Pharmacy: ______________________ Phone Number: ______________________

The Health Center has my permission to administer at no charge the following over-the-counter medications at the discretion of the medical provider. Please check.

☐ Tylenol       ☐ Ibuprofen       ☐ Throat Lozenges       ☐ Benadryl       ☐ Claritin
☐ Cough Syrup   ☐ Anti-diarrheal ☐ Antacids               ☐ First Aid Creams

My child has had a complete physical (well child) exam in the past year ☐ Yes ☐ No Date: ______________
If no, would you like us to complete their physical (well child) exam at the SBHC? ☐ Yes ☐ No
(CCWV will contact you prior to performing this exam to discuss any health issues or concerns you may have in regards to your child.) ***Please note, a sports physical is not a well child exam.

The Health Center can provide your child with the required immunizations for school along with the recommended immunizations by the Center for Disease Control (CDC). These immunizations can be given at no cost to you through the Vaccines for Children Program (VFC) or billed through your insurance which normally covers preventative services, i.e. immunizations, at 100%. CCWV will check with your insurance carrier on coverage of immunizations prior to being given.

I give permission for the school to share their immunization records with CCWV for the purpose of obtaining the most complete immunization records possible. ☐ Yes ☐ No

The Health Center will attempt to contact you prior to your child receiving immunizations; however, if CCWV is unable to reach you, your child will be given a note to bring home with the immunization(s) given. **No immunizations will be given without your permission.** Please check the following:

☐ I would like my child to receive the WV State required immunizations.
☐ I would like my child to receive the recommended immunizations. (HPV, Flu, Hepatitis A, Meningitis B)
☐ I do not want my child to receive immunizations.

***Please send a copy of your child’s immunization record if you have it.

The Health Center will make every attempt to contact you if your child needs to be sent home from school due to illness or injury. In case you are unavailable to be reached, please list the emergency contact(s) who CCWV may call and who have been granted your permission to pick up your child.

Name: _______________________________ Relationship: _____________ Phone: ____________________

Name: _______________________________ Relationship: _____________ Phone: ____________________

Parent/Guardian Signature: ________________________________ Date: ______________

Print Name: __________________________________________________________________________