Community Care of West Virginia

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
(304) 473-5600

For assistance outside regular hours of operation, including medical questions and/or prior to a visit to the ER, please call 888-557-2298.

Community Care of West Virginia

SCHOOL-BASED HEALTH CENTER (SBHC) ENROLLMENT

Student's Name: _____ Date of Birth: _____
Student Social Security #_____ Check one: ☐ Male ☐ Female
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 or 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) _____
_____
_____

Student's Name:_____ Date of Birth:_____

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 telehealth.
- ☐ 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 throughout all years my child is enrolled in school or until I revoke it. 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 following 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: _____

Community Care of West Virginia

FLU QUESTIONNAIRE

Patient Name: _____ Date: _____

Address: _____ Phone: _____

_____

For adult patients, as well as parents of children to be vaccinated:
The following questions will help us determine if there is any reason we should not give you or your child the injectable influenza vaccination today. If you answered "Yes" to any of the questions, it does not necessarily mean you or your child should not be vaccinated. It does, however, mean additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it further.

SCREENING QUESTIONNAIRE FOR THE INJECTIBLE INFLUENZA VACCINE

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs* or a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome?	☐	☐	☐

***If you would like your child to receive a flu vaccine this year, please complete this form and return it with the SBHC Enrollment Form. 2018 CDC Guidelines say that people with egg allergies can receive any licensed, recommended, age-appropriate flu vaccine. People who have severe egg allergies should be vaccinated in a medical setting, supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.**

Parent/Guardian Signature: _____

STOP

Fluzone Flulaval Fluarix Fluzone High Dose Other _____
Afluria FluBlok Fluad
Lot # _____ Expires _____

Form completed by: _____ Electronic entries by: _____