my health e schools

MINOR PATIENT REGISTRATION The Center for Rural Health Innovation

By completing this form, I consent in advance to my child having access to any or all-available services of MY Health-e-Schools as long as my child remains enrolled in Mitchell or Yancey County Schools. Services include: diagnosis and treatment of common illnesses and injuries; laboratory testing; preventive health screenings; health education; mental health services and referrals as needed.

Students must have parental permission to be seen by MY Health-e-Schools.

Student's Name (First, Middle, Last): _____

DOB: _____ SSN: _____ Age: _____ Gender: M F School: _____

Mailing Address: _____City: _____ Zip: _____

Primary Phone: _____ Parent Email: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ 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: _____ Ph.: _____

Person Responsible for the Bill: _____

Is the Patient covered by insurance? YES or NO.

Please fill in all of the following:

Primary Insurance Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Secondary Ins. Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber: _____ DOB: _____ SSN: _____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER: _____

Primary Care Doctor/Clinic: _____

Pharmacy: _____Town: _____

No Services can be provided without the following page completed and signed.

(OVER)

Child's Name: _____DOB: _____

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. MY Health-e-Schools staff will share confidential information only in the following situations:

- when it is educationally relevant for a student's academic progress,
- when necessary to address a student's potential health care needs,
- to ensure the safety of the student, other students and school personnel
- other situations specified by law.

For example, the MY Health-e-Schools staff may discuss the student's medication and other health care needs with the appropriate staff members who will administer the student's medication and provide care to the student while the student is at school.

Additional detailed information about the Privacy Policies that govern the MY Health-e-Schools Telemedicine Program are available on our website at www.crhi.org and at each school nurse office.

I, the undersigned,

- give permission and consent for my child to have treatment through and by MY Health-e-Schools. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- give permission for MY Health-e-Schools to receive information from the school about my child's health history.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website www.myhealtheschools.org or at the school nurse office).
- agree to release all records related to this treatment to the Primary Care Provider
- agree that all I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
- As Parent/Guardian of the above student, I:
  - authorize the release of any information necessary to process insurance claims for payment of benefits to MY Health-e-Schools.
  - authorize payment of benefits to MY Health-e-Schools for services rendered.
  - have provided details of all insurance policies that cover my child.

The information above and on the proceeding page is true and complete to the best of my knowledge.

Parent/Guardian name PRINTED: _____

Parent/Guardian SIGNATURE: _____

Date: _____

MY Health-e-Schools Student Health Questionnaire

Students must have parental permission to be seen by MY Health-e-Schools.

_____ _____ _____

Student's Last Name First Middle

_____

Student Date of Birth Gender School

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

- ☐ Allergies, other than medications (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
- ☐ Heart Problems - *Please list* _____
- ☐ Bleeding Disorders
- ☐ Orthopedic (bone or joint) Problems
- ☐ Anxiety/Depression
- ☐ Operations and/or Hospitalizations - *Dates (details below)* _____
- ☐ Diseases in Siblings
- ☐ Other - *Please explain* _____

***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* _____

In signing this form, I am stating the following:

- *The information that I have provided is accurate and up-to-date.*
- *I will update MY Health-e-Schools with any changes as soon as possible.*

If you would like to speak with our medical provider about any of your child's health, please contact MY Health-e-Schools at (828) 467-8815.

_____ _____

Parent/Guardian Signature Date 005.MYHS