AudubonArea Community Care Clinic, Inc.

Owensboro School Health
Registration Form

District: ______________________

School: ______________________

Grade/Teacher: ______________________

2022-2023 School Year

PATIENT INFORMATION
Please complete the following information about your child:

Child's Last Name: First: Middle: Date of Birth: Social Security #:

Sex Assigned at Birth: ☐ Male ☐ Female First & Last Name of ALL Parents/Guardians:

Street Address: PO Box: City: State: Zip:

Guardian Home Phone: Guardian Cell Phone: Guardian Work Phone:

Emergency Contact Name & Phone (Other Than Guardian):

What pharmacy do you use? City: Phone:

Language: ☐ English ☐ Spanish ☐ Other: Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

As a Federally Qualified Health Center, Audubon Area Community Care Clinic is required to collect the following information to ensure we are providing the appropriate medical care and financial assistance, as needed.

How many people live in your home? What is your annual household income?

Does your child have a Primary Care Physician? If so, who? ☐ Yes ☐ No Name of PCP if applicable:

Would you like for your child's visit notes to be sent to their primary care physician? ☐ Yes ☐ No ☐ N/A

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name: ID Number:

Group Number: Address of Policy Holder (if different than patient):

Whose name is on the policy? Policy Holder's Date of Birth: Relationship to Patient:

☐ Check this box if you do not have medical insurance. *You may be contacted by our Patient Financial Services department.*

Past Medical History

- ☐ No Past Medical History
- ☐ Asthma
- ☐ Anxiety
- ☐ Congenital Heart Defect
- ☐ Concussion or Head Trauma
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Hernia
- ☐ Sickle Cell Anemia
- ☐ RSV
- ☐ MRSA Skin Infection
- ☐ COVID-19 Date of Diagnosis ______________________
- ☐ Allergies
- ☐ Autism
- ☐ Cardiomyopathy
- ☐ Diabetes Type I
- ☐ Gastric Reflux
- ☐ High Blood Pressure
- ☐ Speech Disorder
- ☐ Meningitis
- ☐ Developmental Learning Disorder/Delay
- ☐ Other ______________________
- ☐ ADHD
- ☐ Anemia
- ☐ Cerebral Palsy
- ☐ Diabetes Type II
- ☐ Heart Murmur
- ☐ Hypothyroid
- ☐ Chicken Pox
- ☐ Smoking

Past Surgical History (with date included)

- ☐ No Past Surgical History
- ☐ Tonsillectomy: ______________________
- ☐ Adenoidectomy: ______________________
- ☐ Appendectomy: ______________________
- ☐ Ear Tubes: ______________________
- ☐ Incision and Drainage: ______________________
- ☐ Other: ______________________

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Family History (Please label below with : **M** for Mother, **F** for Father, **S** for Sibling, and **G** for Grandparent.)

- ☐ Anxiety___
- ☐ Diabetes Type I___
- ☐ Hypothyroidism___
- ☐ Unexpected or unexplained death before the age of 35 years?___
- ☐ Asthma___
- ☐ Diabetes Type II___
- ☐ Heart Murmur___
- ☐ Congenital Heart Defect ___
- ☐ Epilepsy/Seizures___
- ☐ Pacemaker___
- ☐ Cardiomyopathy___
- ☐ High Blood Pressure___
- ☐ Sickle Cell Anemia___
- ☐ Unknown
- ☐ Depression___
- ☐ High Cholesterol___

OVER →

Student Medical History

AudubonArea Community Care Clinic, Inc.

Does your child currently take any medications? ☐ Yes ☐ No
Please list any medications with current dose (how much and how often):

____

____

Emergency medication kept at school? ☐ Yes ☐ No ______________________
Is your child allergic to any medications? ☐ Yes ☐ No ______________________
Is your child allergic to environmental factors (bees, latex, nuts, food, etc.)? ☐ Yes ☐ No
Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.):

Name of Allergen	*Type of Reaction*

Who is your child's dentist? ______________________

Please read carefully, COMPLETE FORM, SIGN, and DATE. Please notify Audubon Area Community Care Clinic if there are any health changes or a change in guardianship. Consent will not expire until your child leaves the District or Audubon Area Community Care Clinic is notified in writing that you wish to revoke such.

I give my consent for ______________________ ______________________ ______________________
Student's Full Name ***Birth Date*** ***Social Security Number***

to receive the following services at Audubon Area Community Care Clinic School Based Health Centers (PLEASE INITIAL): __________

_____ ***School Nurse Services Only*** (Including illness assessment, emergency medication administration, OTC medications, basic triage) completed by an APRN, RN, LPN, or MA. The following over the counter medications are available to your child by the school nurse if the symptoms deem necessary:

Calamine	Antacid (Tums)	Antibiotic Ointment (Polysporin)
Hydrocortisone cream	Benadryl	Claritin (for allergies)
Orajel	Cough Drops	Sunscreen
Tylenol	Aloe Vera	Icy Hot (high school only)
Motrin/Advil	Anti-itch Spray	Guaifenesin

****If you do NOT consent for your child to have any of the medications listed, please draw a line through the medication and initial beside it.***

_____ ***Nurse Practitioner/Physician Assistant/Telehealth Services*** ***If you would like to be contacted prior to the exam, please initial*** _____.
(NP/PA/Telehealth services for acute illness, wellness exams, CLIA waived testing, sports physicals, etc.)

_____ ***Well Child Exam*** (Yearly physical to assess height, weight, vision, hearing, anticipatory guidance, etc.). ***If you would like to be contacted prior to the exam, please initial*** _____ ***Date of last wellness exam if known:*** ______________________

_____ ***No Services at this time from Audubon Area Community Care Clinic.***

I give consent to Audubon Area Community Care Clinic School Based Health Center (hereinafter AACCC) staff to render the needed treatment, perform the needed test(s), and document attendance, immunizations, and review/document on KYIR, eCW, or Infinite Campus any other information, if applicable, that will assist the staff in providing care for the patient/my-self/my child. I understand that AACCC shall provide a copy of its Notice of Privacy and HIPAA Practices upon my request, which is also available at www.audubon-area.com/clinic.html. ***I authorize AACCC to release any information required for payment of insurance claims and authorize my insurance, Medicare or Medicaid to be paid directly to the clinic. I understand I am responsible for any co-payments and/or deductibles incurred from my insurance plan.*** *If this cannot be done, I agree to make arrangements with the clinic. I authorize AACCC staff to release and receive medical information from the patient/my primary care providers and specialists. I give consent for this protected health information to be shared with school district staff who may need to provide care in an emergency situation. Furthermore, I give consent for AACCC staff, Board of Education staff, and the patient/my primary care provider, to communicate and share medical and psychological conditions on an as needed basis with the understanding that all information will be treated in a confidential manner.*

SIGNATURE REQUIRED

Parent/Guardian Signature	***Print Name***	***Date***
Patient Signature (if 18 years or older)	***Print Name***	***Date***

CONSENT FOR CARE USING TELEHEALTH

Physicians, and other medical personnel such as advance practice registered nurses, and other types of providers such as registered nurses, psychiatrists, pharmacists, social workers, therapists and community health workers are called "providers" on this form.

I understand that the Audubon Area Community Care Clinic teaches and trains doctors and other health care providers. Doctors in training (residents), medical students and other healthcare trainees may be involved in my care with appropriate supervision.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand.

My provider has told me there could be problems when using telehealth. Possible problems include:

- A telemedicine exam may not give the information needed to make a clinical decision. Information transmitted may not be sufficient (e.g. poor resolution of video/images) to allow for appropriate treatment.
- Technology problems may delay medical evaluation and treatment for the telehealth visit.
- Security measures may fail, causing a breach of privacy of personal medical information. This is very rare.
- Telehealth does not provide direct treatment, including emergency care.

For Direct-to-Consumer telehealth patients:

- Lack of privacy at the patient's location or because the patient may use a non-secured or shared device.
- Interruption of the visit due to local factors or technology problems.

My provider has also told me about the possible benefits of the procedure. Possible benefits include:

- Improved access to care. A patient can get services from anywhere in Kentucky.
- A patient can receive care from home, working with local providers to maintain continuity of care.
- Less time and expense for travel.

I understand the originating site provider may provide certain services using telehealth technology, including transmission of images, video and audio that are encrypted for privacy. I understand that these images will be used for diagnosis, treatment or consultation, as well as for educational purposes only within Audubon Area Community Care Clinic. I understand that none of the telehealth sessions will be recorded or photographed.

I understand that someone from Audubon Area Community Care Clinic may contact me in the future to ask me about my health. By signing below, I understand the following:

1. This consent is in addition to any consent I gave for the care I am receiving.
2. This consent is for all the visits that include telehealth, and is valid for up to one year. In order to participate in telehealth, I must reside and by physically present in the state of Kentucky.

3. I am receiving telehealth services at the location of my choice, and I assume the risks that were discussed with me.
4. The laws that protect privacy and confidentiality of medical information also apply to telehealth.
5. There may be occasions that it will be necessary for a technician to assist with telehealth equipment. I will be informed prior to a technician joining the telehealth session. Such technicians will keep any information confidential.
6. Telehealth visits are done over a secure communications system that meets HIPAA encryption standards, but there is no guarantee that a security breach is not possible, and I accept the risk that this could affect confidentiality.
7. I have the right to withdraw my consent to the use of telehealth in the course of my care at any time. This will not affect my right to future care or treatment.
8. My provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. If my provider believes I would be better served by a traditional in-person office visit, he or she may at any time stop the telehealth visit and schedule an in-person visit for certain diagnosis and treatment or in the event of a technical failure.
9. No results are guaranteed or promised by using telehealth for care.
10. My demographic information may be shared with other individuals for scheduling and billing purposes.
11. I or my insurance may be billed for telehealth services. I am responsible to Audubon Area Community Care Clinic for charges resulting from the services provided via telehealth.
12. If my provider sees or hears anything that shows I have an emergency medical condition, he or she may call 911.
13. Law may require my provider to report certain events, such as self-neglect or if someone is in danger.

NOTE: Interpretive services **must** be offered for preferred languages other than English.

I have read this consent form, and it has been explained to me. I have received information regarding telehealth and have had the chance to ask all of the questions I have about telehealth, its alternatives, its risks, its benefits, and limitations. I have been given answers to my questions, and I understand the answers.

Signatures

____
Patient

____
Signature of Legal Representative and Relationship to Patient

____
Person obtaining consent Date / Time

____
Interpreter Name or ID # In person or via Interpretation Service(circle one)

Authorization to Release Healthcare Information

Patient Name: ___________________________________ Date of Birth: _________________________

Emergency Contact

Emergency Contact Name: ____
Relationship to Patient: ____
Phone Number: ____
Work Number: ____

1. Audubon Area Community Care Clinic will send test and lab results to the home address you have listed and will leave detailed phone messages on the home/cell phone you have given. If you would like to refuse mail, phone calls and/or detailed phone messages, please indicate so below:
   ____

2. I request and authorize Audubon Area Community Care Clinic to release healthcare information to the following person(s):
   Name(s): ____

   This request and authorization applies to:
   ☐ Appointment Date, Time, and Location
   ☐ Prescription Information (including picking up prescriptions)
   ☐ All Medical Information- Except HIV test results, drug, alcohol, or mental health treatment records and information regarding pregnancy or STDs

The person(s) listed above will be notified that I must give specific written permission before disclosure of HIV test results, drugs, alcohol, or mental health treatment records or information regarding pregnancy or STDs to anyone.

☐ Yes ☐ No I authorize the release of information regarding pregnancy, STD testing and treatment to the person(s) listed above.
☐ Yes ☐ No I authorize the release of my HIV status, whether negative or positive, to the person(s) listed above.
☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Dates of Information to be Disclosed:
☐ No Date Restrictions
☐ Specific Dates: ____
Signature: ________________________________ Date: ____________________________________

____ _____________________________________
Name (Parent, guardian, legal representative) Relationship to Patient