2021 - 2022

[ ] Scanned [ ] Updated School:

Registration Form
School Health Services
Coastal Family Health Center, Inc
CONSENT FOR HEALTH CARE

Services rendered with $0 out of pocket expense

FLU SHOT
__ **Yes** my child may receive the seasonal flu vaccine for 2021-2022
___ **No** I do not wish for my child to receive the seasonal flu vaccine

Student Information
Name:_____ DOB: _____ Social Security Number: _____
Address: _____ Race:____ Sex: __ Male __Female Ethnicity: _____
Phone #: _____ Email: _____ Cell Phone #: _____
Student's Legal Guardian: _____ Student's Primary Caregiver: _____
Child Lives With: __Mother __Father __Grandparents __Both Parents __Grandmother __Grandfather __Aunt __Uncle
Does Student have Advance Directive? __Yes __No
Mother's Name: _____ DOB: _____ SSN: _____ Phone #: _____
Place of Employment: _____ Work#: _____
Father's Name: _____ DOB: _____ SSN: _____ Phone #: _____
Place of Employment: _____ Work#: _____

Emergency Contact Information *(Emergency contacts should be contacted if parent is unavailable)*
Name:_____ Phone#_____
Name:_____ Phone#_____

HealthCare Information
Primary Care Provider: _____ Phone#: _____
Preferred Pharmacy: _____ Phone#: _____

Insurance Information (Please check one that applies)
____We do not have insurance that covers the student
____Student is covered by Medicaid#_____
____ Student is covered by CHIP#: _____
____Student is covered by private insurance. Policy Number:_____ Group#: _____
Name/Address of Insurance Company: _____
Policy Holders Name: _____ DOB: _____ Address:_____
Employer Name: _____

Annual Household Income: Please circle the appropriate amount (required for grant information)

$0-10,000	$10,001-20,000	$20,001-30,000
$30,001-40,000	$40,001-50,000	$50,001-up

Student Medical Information
1. List any medications: Name, dose and directions on medication _____
_____
2. List any allergies to medications or shots _____
3. List any allergies to foods or other non-medication items?_____
4. List any specialist the patients sees for care_____
5. List any operations/ surgeries_____
6. Has the student ever been hospitalized?(Please put date and reason)_____
_____
7. Is the student on a special diet?_____

STUDENT HISTORY

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	ADHD	[ ]	[ ]	Diabetes	[ ]	[ ]	Seasonal Allergies
[ ]	[ ]	Anemia	[ ]	[ ]	Hernia	[ ]	[ ]	Sickle Cell Anemia
[ ]	[ ]	Asthma	[ ]	[ ]	Loss of Hearing	[ ]	[ ]	Stomach Problems
[ ]	[ ]	Epilepsy/Seizures	[ ]	[ ]	Loss of vision	[ ]	[ ]	Trouble Speaking
[ ]	[ ]	Other:_____						

TOBACCO

Exposure to second hand smoke? Yes___ No___; Inside___ Outside___

FAMILY HISTORY

If there is any family history of the following, please "X" and indicate the relationship of the family member(s) to student.

Please indicate Mother, Father, Maternal/Paternal grandmother or grandfather (M, F, MGM, MGF, PGM, PGF)

___Arthritis_____
___Cancer/Type:_____
___Diabetes_____
___Heart Attack_____
___Heart Disease _____
___Hepatitis_____
___High Blood Pressure_____
___Kidney Disease_____
___Mental Illness_____
___Sickle Cell Anemia_____
___Stroke_____
___Thyroid Problems_____
Other_____
_____
_____

OTHER COMMENTS

Please list any other comments or concerns regarding the student's health: _____

Can the School Health Services perform the yearly wellness visit for your child? ___Yes ___No

VACCINE CONSENT

If Yes, please select vaccines below:

_____ Yes my child may receive the selected vaccines

_____No I do not wish for my child to receive vaccines

The School Health Service Clinics will be working with your child's school to give recommended/required vaccines to children during their wellness visit if needed at school. There will be no cost to you for these vaccines. You have received this letter because your child's wellness exam is due soon. Vaccinations **WILL NOT** be given without prior consent.

The vaccine consent form includes options allowing you to either **accept or refuse** the recommended vaccinations for your child. If you refuse, the vaccinations will not be given to your child.

Please place a mark on **accept or refuse** by each vaccination. The recommended/required vaccinations are checked with MS immunization records state website prior to administration. Make sure you sign below.

VACCINATIONS	ACCEPT	REFUSE
Hepatitis A		
HPV (Human Papillomavirus)		
Meningococcal ACWY and MPSV4		
Meningococcal B		
Pediarix (Polio, Tetanus, Diphtheria, Pertussis)		
Tdap (Tetanus, Diphtheria, Pertussis)		
Kinrix (Dtap/IPV)		
ProQuad (MMRV)		

A signed consent is necessary before we are able to provide services to your child. I give permission for my child to be seen at Coastal Family Health Center, Inc and to receive health related services. I understand Coastal Family Health Center will notify me by phone or written note of any atypical results requiring treatment, follow-up, or referral. I hereby authorize Coastal Family Health Center to release any information acquired in the course of treatment so insurance benefits may be promptly and correctly filed. This authorization is valid for the 2021-2022 school year and I retain the right to withdraw permission for services at any time. I understand my child's medical records and the results of all examinations are strictly confidential and that this authorization is limited to the services described below. **I hereby give consent for all the services rendered at Coastal Family Health Center Inc including: assessment, diagnosis and treatment of minor illness and injury; identification of and referral for treatment of chronic conditions; sports (including hernia checks for males) and routine physicals; health care screenings; immunizations; physical/developmental screenings; prescribe/dispense medications; laboratory tests (blood, urine, throat, nasal), follow- up if requested by a family medical provider; individual and/or group health education; procedures including but not limited to ear irrigations, hearing/vision and scoliosis screenings; nutrition services/counseling; emotional, behavioral, or adjustment issues counseling that presents barriers to academic success and tuberculin testing**. Coastal Family Health Center Inc does **NOT** prescribe/dispense contraceptives in the school clinics.

I may decline any of the services listed above. I wish to decline the following services at Coastal Family Health Center Inc (write in the response on lines below for the services you wish to decline).

_____

_____

_____

Parent Signature:_____

Date:_____

ACKNOWLEDGMENT OF RECEIPT OF COASTAL FAMILY HEALTH CENTER/SCHOOL HEALTH SERVICES' NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed Coastal Family Health Center/School Health Services' Notice of Privacy Practices and I received a copy of the notice to retain for my records.

Student Name _____ Date _____

Parent/Guardian Signature _____

Parent/Guardian Printed Name _____

RELEASE OF INFORMATION

We may release personal/confidential information of the patient to persons listed below:

Name:_____ Phone#_____

Name:_____ Phone#_____

Name:_____ Phone#_____

No student seen at any of the School Health Services sites should receive a bill for services from the School Clinic or Coastal Family Health Center, Inc. This includes students with or without insurance. If you do receive a bill, please contact our office.

Coastal Family Health Center/School Health Services Use ONLY

Date acknowledgement received: _____ Staff Initials:_____

Return To School Health Service

NOTICE OF PRIVACY PRACTICES (Short form)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of (PHI (PHI) for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at CFHC may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at CFHC or the hospital. For example, we may disclose medical information about you to people outside CFHC who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run CFHC and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Center's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Center personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at Coastal Family Health Center. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Coastal Family Health Center, whether made by Center personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Coastal Family Health Center. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from Coastal Family Health Center. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in CFHC's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with CFHC or with the Secretary of the Department of Health and Human Services. To file a complaint with Coastal Family Health Center, contact our Privacy Officer at 228-374-2494, , 1046 Division St. Biloxi, MS 39530. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.