STUDENT HEALTH CENTER

Central Curry School District

What is a School-Based Student Health Center?
A School-Based Health Center is much more than the traditional school nurse's office. It is a medical facility located in the school that offers many health and medical services like your doctor's office (see list below). We do not replace your primary doctor, and all of our services are provided at one of the participating schools. The Student Health Centers are operated by Coast Community Health Center through an agreement with Central Curry School District.

Who works at the Student Health Center?
Our staff includes Family Nurse Practitioners (FNP), who can treat most health problems and prescribe medications, registered nurse (RN), medical assistants (MA), and support staff. Mental health counseling and/or referrals to mental health/drug and alcohol services are also available. All staff are supervised by and have support of the Coast Community Health Center physicians and Chief Medical Officer.

What services are offered?
We can take care of most of your student's health care needs. If there is an emergency or service we do not provide, we contact 911 or will make a referral to another health care provider. When the health center is not open or staff is unavailable, school personnel will follow school guidelines for all emergency situations.

- Wellness and how to maintain it for a lifetime
- Physical examinations, routine, and sports
- Mental health services and counseling
- Referrals to other health care providers
- Immunizations and flu shot
- Assessment of health strengths and challenges
- Nutrition education and weight management
- Diagnosis and treatment of minor illness
- Dental screening
- Vision and blood pressure screening
- Tests such as anemia, diabetes, and infection

What about costs and billing?
Coast Community School Based Health Center wants to provide health care for all students who need it. Many of our services are provided at no charge; however, there are some services that we provide that require an exam and medical action that **may** result in a charge. No student will be turned away due to inability to pay. Examples of some of these services include:

Sore Throat
Ear pain
Cough
UTI symptoms
Sprain/fracture
Head injury
Pink eye
Abdominal pain
Foreign body in eye
Follow-up visits
Well Child checks
Immunizations

If a visit does result in a charge, we will bill your insurance for you, including the Oregon Health Plan. We also offer a sliding discount program which is based on your family size and income. Anyone can apply for this program even if you have insurance. We encourage all families to complete an application. An office visit summary will be sent home after a billable service is provided.

What about parental consent?
At the health center we require parental/guardian signed consent for a student to use our services.
*We support and encourage parental involvement in decisions about your student's health care.

What about confidentiality?
Our health services and records are private and confidential. Health records will not become a part of your student's school record and will only be used by health center staff unless you give us written permission to share information.

Like other health care providers, the Student Health Center follows the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA regulates how medical information may be used and disclosed and how you can get access to this information. We are required to give you a copy of our Notice of Privacy Practices and have you sign the Acknowledgment and Consent which is included in the packet.

Students will be encouraged to discuss visits with their parents; however, confidentiality will be provided at the student's request. Oregon State Law (ORS 109.610, ORS 109.640, and ORS 109.675) requires strict confidentiality regarding evaluation, diagnosis and/or treatment for sexually transmitted diseases, sexuality issues, pregnancy testing or mental health services.

What about appointments?
Appointments are encouraged whenever possible. A parent may call and make an appointment, or your student is welcome to come by and schedule an appointment. Hours will be posted on the clinic door and in the school bulletin.

La escuela esta dispuesto a ayudar a sus estudiantes hispano hablantes ya sus padres con traducciones cuando sea necesario. Los programas de esta escuela están abiertos a todos los estudiantes sin discriminar por razones de sexo, raza, ni impedimento físico.

The school can arrange to help Spanish speaking students and their parents with translation when necessary. The programs of this school are open to all students without discrimination for reasons of sex, race, or inability to pay.

**Oregon State Law (ORS 109.610, ORS 109.640) requires a parent or guardian's signature for medical treatment for students less than 15 years of age, with the exception of treatment for sexually transmitted diseases and for birth control information and services. Oregon State Law (ORS 109.675) states that a student 14 years and older may obtain mental health and chemical dependency treatment without parental knowledge or consent.*

STUDENT HEALTH CENTER

INFORMED CONSENT TO TREAT

Student Name: Last	First	Middle Initial	Date of Birth

Parent/Guardian Name	Relationship to Student	Home Phone

All services are provided at Coast Community Health Center School Health Center and by signing yes on this consent form you **do not** replace your primary care provider. Services that are provided to students may be billable. However, services will not be withheld for inability to pay. For elementary age students, we will always ask for permission from the parent before administering or prescribing medication except in the case of an emergency. An emergency would be a high fever (greater than 102 degrees Fahrenheit), a severe allergic reaction, or severe breathing difficulties. In this situation, we will give immediate treatment to your child following our protocols. For other children in middle and high school, unless you ask us not to in writing, we may administer over the counter medications for minor conditions. This usually means cough drops for sore throats or coughs, generic Tylenol to reduce fever or headaches, generic Ibuprofen for headaches or cramps, generic Benadryl for allergic reactions. If your child has a breathing problem, we may also use an Albuterol inhaler according to our protocol. For middle and high school students, an attempt will be made to contact the parent/guardian by phone or letter if prescription medications are indicated. If you have any questions about our medication policies, please contact the School Based Health Center.

☐ **YES** **I consent to health care services offered by the Student Health Center for the above-named student. I understand that this consent is valid as long as my student is enrolled in a school served by a Coast Community Health Center School Health Center, unless terminated in writing. In accordance with Oregon Law, minors who are 15 years or older are able to consent to medical and dental services without parental consent. In addition, minors 14 years or older are able to consent to behavioral health services without parental consent.**

☐ **NO** **I do *not* give my consent to services offered.**

The American Academy of Pediatrics recommends children have a comprehensive physical exam performed every year. If your child is due we will schedule them for a well child exam during the school year. If you do NOT want your child to receive a well child exam, please indicate here:

☐ **NO** I do NOT want my child to have a comprehensive physical exam this year.

Parent/Guardian Signature **Date**

STUDENT HEALTH CENTER

FAMILY HEALTH HISTORY

Student Name:_____DOB:_____Today's Date: _____

Medicine Allergies: _____

STUDENT MEDICAL HISTORY		
Yes	**No**	**Has this student had any:**
☐	☐	Chronic or recurrent illness such as diabetes, seizures, cancer, hepatitis, mono?
☐	☐	Hospitalization/Surgeries?
☐	☐	Urinary, kidney problems, undescended testicles?
☐	☐	Missing or damaged organs (eye, kidney, testicle)?
☐	☐	Problems with heart or blood pressure?
☐	☐	Chest pain with exercise? Wheezing? Cough?
☐	☐	Dizziness or fainting with or without exercise?
☐	☐	Frequent headaches, anemia, bleeding, or blood clot problems?
☐	☐	Allergies, asthma, severe bee sting reaction?
☐	☐	Learning disorders or slowed development?
☐	☐	Vision or hearing problems?
☐	☐	Chicken pox? If yes, what year? _____
		Does this student:
☐	☐	Wear eyeglasses or contact lenses?
☐	☐	Wear dental bridges, braces, plates?
☐	☐	Take any medication on a regular basis? (prescription or over the counter)
		Is there a history of:
☐	☐	Concussion, loss of consciousness, convulsions?
☐	☐	Injuries to neck, knees, ankles?
☐	☐	Broken bones, joint injury, disease, or dislocation?
		Has student had:
☐	☐	2nd measles, mumps & rubella vaccine (MMR)?
☐	☐	Hepatitis B vaccine series?
		Year of last tetanus vaccine? _____

FAMILY MEDICAL HISTORY		
Yes	**No**	Has any family member died suddenly at less than 50 years of age of causes other than an accident?
☐	☐	

Signify health conditions which occur in the family. Include natural parents, brothers, sisters, and grandparents.

Yes	**No**		**Who?**
☐	☐	Allergies	_____
☐	☐	Asthma	_____
☐	☐	Birth Defect	_____
☐	☐	Bleeding Disorders	_____
☐	☐	Breast Problems	_____
☐	☐	Cancer	_____
☐	☐	Diabetes	_____
☐	☐	Gallbladder Problems	_____
☐	☐	Headaches	_____
☐	☐	Heart disease/Heart Attacks	_____
☐	☐	Hepatitis	_____
☐	☐	High Blood Pressure	_____
☐	☐	Kidney Disease	_____
☐	☐	Obesity	_____
☐	☐	Sickle Cell Anemia	_____
☐	☐	Seizures	_____
☐	☐	Stroke	_____
☐	☐	Thyroid Disease	_____
☐	☐	Tuberculosis	_____
☐	☐	Other:	_____
			_____

Date of last dental exam:_____ Date of last well child exam/sports physical: _____

Use the space below to explain any of the **YES** answers or to provide any additional information:

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**

Form 2030 062518

STUDENT REGISTRATION
FOR SCHOOL-BASED HEALTH CENTER

Welcome to Coast Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have questions about your care. If you have questions about clinic policies or procedures, please speak with the clinic manager: Lena Hawthorne, RN, (541) 332-1114 ext. 161

Date: _____

STUDENT INFORMATION

Last:_____First:_____MI:_____Δ Jr. Δ Sr. Δ III

Other Names Known By: _____

Social Security #:_____-_____-_____ Date of Birth:_____/_____/_____ Gender: Δ Male Δ Female

RESPONSIBLE PARTY NAME

Last:_____First:_____MI:_____Δ Jr. Δ Sr. Δ III

Relationship to Patient:_____Social Security #:_____-_____-_____

Gender: Δ Male Δ Female Date of Birth:_____/_____/_____

Mailing Address:_____Apt/Unit: _____

City:_____State:_____Zip: _____

Street Address **(if different from above)**:_____Apt/Unit: _____

City:_____State:_____Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

May we leave a message? Δ Yes Δ No ***May we leave a message?*** Δ Yes Δ No

Where does your child usually go for health care? _____

INSURANCE

☐ Private Insurance ☐ Oregon Health Plan (OHP) ☐ Self Pay

PRIMARY INSURANCE *If you have insurance (including OHP) please fill out this section.*

Company:_____ **Policy/ID#:**_____

Policy Holder's Name:_____ Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE *As a courtesy to our patients, we bill most secondary insurances.*

Company:_____ **Policy/ID#:**_____

Policy Holder's Name:_____ Date of Birth: _____

Relationship to Patient: _____

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars, we are required to gather, on a yearly basis, the following statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

STUDENT STATUS
- ☐ Full-Time
- ☐ Part-Time
- ☐ Not Applicable

PRIMARY LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other _____

Do you need an interpreter?
- ☐ Yes
- ☐ No

STUDENT PRIMARY RACE
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian (White)
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

HOMELESS
- ☐ Yes
- ☐ No

Gross Annual Household Income

$_____
**Annual income amount is gathered for grant funding requirements.*

_____ # Members in Family

PRIVACY PRACTICES – ACKNOWLEDGEMENT

I understand that the Student Health Center, operated by Coast Community Health Center (referred to below as "This Practice") will use and disclose health information about me which may include information both created and received by This Practice, may be in the form of written notice or electronic records or spoken words.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for insurance coverage and submit claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for qualify, cost-effective health care.

I acknowledge that this program complies with the HIPAA Privacy Security Act and a copy is available online at This Practice's website at www.coastcommunityhealth.org.

I have the right to revoke this authorization at any time, provided that I do so in writing and to the extent that This Practice has already used or disclosed the information based on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 36 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Parent/Guardian Signature: _____ **Date**: _____

The mission of Coast Community Health Center is to provide a friendly, efficient, and caring environment for the delivery of affordable high-quality healthcare for all.

Coast Community Health Center is a private, not-for-profit equal opportunity provider and employer.

SCHOOL-BASED HEALTH CENTER
Sliding Discount Program Enrollment Form

Coast Community Health Center wants to provide quality health care to our patients, regardless of their ability to pay. This Sliding Discount Program is based solely on family size and income in relation to the federal poverty level for services provided by our School-Based Health Centers (SBHCs).

Enrollment in this program is valid for the school year. To continue being considered for this program, a new Enrollment Form must be completed each school year. If eligible, your child will be able to receive medical care services at our SBHCs free of charge.

Student's Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

Phone: (_____) _____

List household members. This includes yourself, spouse, and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separately.

Name (First and Last)	Relationship	Date of Birth	Gross Monthly Income
	SELF		

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

Signature (Parent/Guardian)_____ Date _____

Print Name (Parent/Guardian) _____

FOR OFFICE USE ONLY

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: $_____

Qualifies for SBHC/Dental Outreach Slide: ❒ Yes ❒ No

_____ _____

Coast Community Health Center Signature **Date**

Coast Community Health Center
Patient Questionnaire Health Assessment: K-4th grade

Student's Name:_____**Date of Birth**: _____

Please help us to provide the best care to your child and family by filling out the following questionnaire. This information will be kept private in your student's medical record and not shared with the school. Any questions you don't feel comfortable answering, please feel free to leave blank. If you would prefer to not fill it out, please check the box below. Thank you for your help.

☐ **I decline to fill out the following questionnaire.**

1. **Does your child make healthy choices by eating fruits/vegetables daily?** ❒ Yes ❒ No
2. **Do they drink milk or eat other dairy daily?** ❒ Yes ❒ No **How much?** _____
3. **Do you put limits on your child's intake of soda and junk fool?** ❒ Yes ❒ No

   How much are they allowed? _____
4. **Does your child engage in physical activity of at least an hour daily?** ❒ Yes ❒ No
5. **Does your child spend less than two hours a day watching TV, playing video games or other screen time?** ❒ Yes ❒ No
6. **Does your child practice good dental hygiene by brushing twice a day and flossing daily?** ❒ Yes ❒ No
7. **Does your child see a dentist?** ❒ Yes ❒ No **When was their last visit?** _____
8. **At home, is your child required to follow good safety and injury protection practices? i.e. always using a seatbelt when riding in a car, and wearing helmets for bike riding or other activities?** ❒ Yes ❒ No
9. **If there is a gun in the home? Is it kept in a locked and secured location?** ❒ Yes ❒ No
10. **Is your child aware of gun safety rules?** ❒ Yes ❒ No
11. **Do you feel your child enjoys school and is doing well with peers and schoolwork?** ❒ Yes ❒ No

    Comments? _____
12. **Does your family enjoy as least one meal a day at the table together?** ❒ Yes ❒ No
13. **If a family member smokes at the child's home, is it done inside or outside?** ❒ No Smoking ❒ Outside ❒ Inside

14. Do you and your child feel safe at your home and in your neighborhood? ❒ Yes ❒ No

Comments?

15. Do you have any concerns about an adult having inappropriate physical contact with your child? ❒ Yes ❒ No

Comments?

16. Do you have any concerns about your child's emotions and wellbeing? ❒ Yes ❒ No

Comments?

17. Does your family experience any of the following? ***Please check all that apply***

❒ Recent move or change in housing ❒ Violence in the home ❒ Separation/Divorce
❒ Job loss or job change ❒ Lack of medical care ❒ Household member dealing with substance abuse
❒ Death ❒ Lack or shortage of food

18. Do you have any other concerns about your child?

STUDENT HEALTH CENTER HOURS

Central Curry School District

Beginning November 2022

Medical Provider

Monday and Thursday
11 am – 4 pm

Behavioral Health Provider

Tuesday and Wednesday
8 am – 1 pm

Please call (541) 332-1114 to schedule
or stop by the Health Center in person!
We are in Room 9 in Gold Beach High School and our mobile trailer is located behind the High School

*Hours subject to expand or change