Roaring Fork School Health Centers
*Keeping our students healthy and ready to learn.*

**ESPAÑOL AL REVERSO**

## REGISTRATION FORM

Date: _____

### Patient Information

Child's Last Name _____ First Name_____ Middle Name: _____
(Please print)

Date of Birth (mm/dd/yy) ____/_____/____ Sex: ☐M ☐F School :☐BES ☐BMS ☐BHS ☐RFHS Other: _____Grade:_____
(Where the student attends)

Please mark the **racial** category you feel most accurately represents your child's background:

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Other or Undetermined
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Do not wish to answer

**If Hispanic/Latino**, please mark the **ethnic** category that you feel most accurately represents your child's background:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Please circle the primary language spoken at the child's (patient) home:

☐ Amharic ☐English ☐Hindi ☐ Korean ☐ Polish ☐ Other:_____
☐ Arabic ☐ French ☐ Italian ☐ Sign Language ☐Russian
☐ Chinese ☐ German ☐ Japanese ☐ Spanish ☐ Vietnamese

If Bilingual, please list the languages spoken: _____

### Family Information

Parent/Guardian #1 Name: _____ Relationship: _____ Phone #: _____
(With whom the child lives)

Parent/Guardian #2 Name: _____ Relationship: _____ Phone #: _____
(With whom the child lives)

Address: _____ Apt # _____ City: _____ County: _____ Zip Code: _____

Mother's Work Place (City): _____ Father's Work Place (City): _____

Preferred way to receive communication from RFSHC: ☐Phone (☐ call ☐text) ☐US Mail ☐Email (please list email address:
_____

Emergency Contact: _____ Relationship: _____Phone#: (_____) _____
(Aside from those that live with child (patient) at home)

### Health Insurance Information

Medical Insurance: ☐Medicaid ☐CHP+ ☐Private ☐No Insurance

Insurance Co. Name: _____ Identification #: _____Group #_____

**How did you hear about RFSHC?** Please mark one:

☐Teacher or School Referral ☐Flyer ☐School Newsletter ☐School Registration Packet ☐Word of Mouth
☐Back to School Night Booth ☐Poster ☐School Website ☐Other:_____

**SIGN HERE**

_____ _____ _____
**Parent/Guardian PRINTED Name** **Parent/Guardian Signature** **Date**

Revised: 08/10/15

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# MEDICAL HISTORY FORM

Student's Last Name: _____ First Name: _____ Date of Birth: _____
(Please print child's (patient) name)

## Patient Medical Information

Is your son/daughter presently taking any medications? Yes ___ No ___

If yes, please fill out this table:

| Type of medication: | Reason for medication: |
|---|---|
| | |
| | |
| | |

Any Major Surgeries (Type, age): _____

Fractures (Type, age): _____

Concussion (Type, age): _____

Allergies: Yes ___ No ___ If yes, what are they?_____

Prior/Current Illness or Condition:

| | Student: | | | | Family Members of Student: | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Comments | | Yes | No | Comments |
| Obesity | | | | Obesity | | | |
| Diabetes | | | | Diabetes | | | |
| Asthma | | | | Asthma | | | |
| Heart Disease | | | | Heart Disease | | | |
| Hypertension | | | | Hypertension | | | |
| Stroke | | | | Stroke | | | |
| Epilepsy | | | | Epilepsy | | | |
| Cancer | | | | Cancer | | | |
| Other:_____ | | | | Other:_____ | | | |

Any Emotional or Mental Health Concerns? Yes ___ No ___ Comments: _____

Any other Health Concerns? Yes ___ No ___ Comments: _____

Would you like to speak with us about ongoing (chronic) health issues? Yes ___ No ___ Explain: _____

Student's usual Health Care Provider: _____

**When was your child's last doctor's visit?** In the last 6 months ___ In the last 12 months ___ In the last 3 years ___ Never ___

**When was your child's last dentist's visit?** In the last 6 months ___ In the last 12 months ___ In the last 3 years ___ Never ___

Does anyone smoke in your household? Yes ___ No ___

_____ _____ _____

**Parent/Guardian PRINTED Name** **Parent/Guardian Signature** **Date**

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**INCOME ATTESTATION**

(Tell us about Your Income)

Student's Name: _____ Date of Birth: _____

(Please print child's (patient) name)

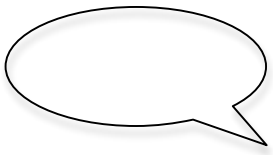
You **MUST** answer the questions below **IF YOUR CHILD DOES NOT HAVE HEALTH INSURANCE** or Medicaid (or if your child's insurance or Medicaid/CHP+ application is pending). If your child does have health insurance benefits that will cover the cost of his/her visit today, you do not need to answer these questions.

How many people live in your household? Circle one:

1 2 3 4 5 6 7 8 9 10

2. Roughly, what is your family's gross total income per year (before taxes)? $_____/year

I confirm that my child does not have health insurance that will cover the services hat he/she is receiving today. I also confirm that, to the best of my knowledge, the family financial information listed above is complete and correct.



_____

Parent/Guardian Signature Date of Services (Today)

Revised: 08/10/15

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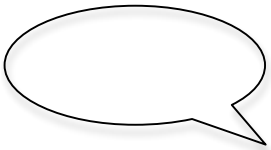
## CONSENT FORM
## Please Read the Following Information Carefully

- I understand that medical and preventive dental services are provided by Roaring Fork School Health Centers (RFSHC).
- I understand that mental health services are provided by either RFSHC or independent mental health providers contracted by RFSHC.
- I understand that RFSHC will make the following services available to my child:
  - Treatment of minor illness and injury
  - Immunizations
  - Routine lab tests
  - Physical / wellness exams
  - Nutritional education
  - Sports physical exams
  - Management of chronic illness
  - Mental health care
  - Preventive oral health care
  - Referrals to community agencies for other necessary care
- I authorize the above services to be delivered to my child as necessary. I understand that the school health staff or RFSHC staff will attempt to notify me prior to my child's encounter with the medical, dental, mental health or nutritional professional, and outcomes except in situations where Federal and/or State law allows students to access such treatment without parent/guardian consent. I give permission for my child to receive care at RFSHC whether or not I can accompany my child to the clinic each time. I understand that I will be informed if RFSHC staff deems the student is a danger for him/herself or others.
- I understand that the RFSHC does NOT offer the following services:
  - Hospitalization
  - Medical X-Rays
  - Pharmacy services
  - Sutures / Casting
  - Treatment of complex medical or psychiatric conditions
  - Restorative dental care
  - Emergency Care (except as required by law)
- I authorize RFSHC staff to disclose all or any portion of my child's medical record to persons or entities, pertinent to his/her health care, including his/her primary care doctor, the school nurse or school health paraprofessional, mental health provider and/or employees of the Roaring Fork School District RE-1 who, as determined by RFSHC, are closely involved with monitoring my child's welfare and have a reasonable need to know such information.
- I further understand that all information in my child's medical record is confidential and will not be released to any unauthorized person or agency without written consent. This practice conforms to Colorado law.
- I understand that this consent includes consent for referral of care and, if needed, to summon emergency services (911), emergency transportation to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the RFSHC' staff. Expenses related to ambulance or other emergency referral will be my responsibility. Nothing in this authorization shall be deemed to modify or limit the responsibility and authority of the Roaring Fork School District RE-1 to deal with emergency medical situations as is appropriate.
- I give consent to the RFSHC staff to review my child's school records, attendance and other records that may assist RFSHC providers to help my child.
- I give consent to release any information regarding treatment to third party payers (insurance) for the purpose of billing.
- I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the RFSHC staff of any change in the child's guardianship.
- This consent for services is authorized for the length of time the student is enrolled in the Roaring Fork School District RE-1. I may withdraw this consent at any time with written notice to the RFSHC.
- I also certify, by signing this form, that I am legally authorized to provide this consent.



_____ _____ _____

**Parent/Guardian PRINTED Name**

Revised: 08/10/15

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## HIPPA A Notice of Privacy Practices

Student's Last Name: _____ First Name: _____ Date of Birth: _____
(Please print child's name)

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

ROARING FORK SCHOOL HEALTH CENTERS (RFSHC) provides health care services to our patients in partnership with medical and mental health professionals and organizations. These privacy practices will be followed by RFSHC. We will share medical information about our patients as necessary to carry out treatment, payment and health care operations.

This Notice of Privacy Practices between yourself and RFSHC will serve as authority to access and share your child's (patient) medical information as outlined by the terms of this Notice.

### I. Understanding the Patient's Health Information.

Each time the patient visit the RFSHC, a record of patient's visit is created. This record usually contains name and other information that may identify the patient, his/her symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as the patient's "medical record" or "medical chart". This record allows:

- Health professionals (medical and mental health providers), and other health staff to plan the patient's treatment.
- RFSHC to obtain payment for services we provide to the patient.
- RFSHC to measure the quality of care provided to the patient.

We are committed to keeping the patient's health information confidential. We will not use or give to others the patient's health information without your written permission, except as stated in this Notice.

### II. How We Will Use and Give Out the Patient's Health Information

**a. Treatment, Payment, and Health Care Operations**

We will use and give out the patient's health information to provide the patient with health care treatments, to get paid for our services, and to help us operate our school-based health center. For example:

- We will give the patient's health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for the patient;
- We may sent you a bill for services;
- RFSHC may use the patient's medical record to review our performance and make sure the patient receives quality health care.

**b. Other Uses and Disclosures Allowed or Required by Law**

AFTER OBTAINING PERMISSION FROM YOU, we may use or give out the patient's health information for the following purposes under limited circumstances:

- To people who are involved in the patient's care or who help pay for the patient's care, such as family members, close family friends, or any other person chosen by you, to notify them of the patient's location, general health, and to assist the patient with his/her health care (such as picking up medicine or helping with follow-up care);
- To government agencies that oversee RFSHC (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);

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## HIPPA A Notice of Privacy Practices Continued

- When law enforcement requests information (such as to prevent danger or injury);
- For research studies that meet all privacy law requirements (such as research to stop diseases);
- To contact the patient about new treatments or medicines that may help him/her.
- To business associates of RFSHC that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep the patient's health information confidential as required by law); and
- For any other purpose required or allowed by law.

**c. We May Use or Give Out the Patient's Health Information WITHOUT YOUR PERMISSION Under the Following Circumstances:**

- When we are ordered by a court or judge.
- To avoid a serious threat to the health or safety of the patient or others.

**d. Other Uses and Disclosures Requiring Your Written Permission:**

Except as stated above; we will use or give out the patient's health information only after getting your written permission on an Authorization Form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

### III. Your Rights Regarding the Patient's Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of the patient's health information, including the rights to:

- Request limits on uses of the patient's health information
- Receive confidential communications of the patient's health information
- Inspect and copy of the patient's health information
- Request a change to the patient's health information
- Receive a record of how we have used and given out the patient's health information
- Obtain a copy of this Notice of Privacy Practices

### IV. Questions, Concerns, and Changes to this Notice

If you believe that the patient's privacy rights have been violated, you may file a complaint with RFSHC, or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. We will not retaliate against you for filing a complaint. We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at RFSHC.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

| _____ | _____ | _____ |
|---|---|---|
| **Parent/Guardian PRINTED Name** | **Parent/Guardian Signature** | **Date** |

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## Health Information Exchange (HIE) – A Notice of Privacy Practices

ROARING FORK SCHOOL HEALTH CENTERS (RFSHC) uses Quality Health Network (QHN) for the secure electronic delivery of your child's (patient) health information to the medical providers who are treating him/her. All participants of the QHN network are legally bound to abide by the HIPAA Privacy Law, and other applicable laws and regulations. By participating in the QHN network RFSHC is able to provide timely information to the patient's team of healthcare providers who participate in QHN.

In addition to the electronic delivery of the patient's health information to his/her treating providers that participate in QHN, the QHN network gathers the patient's health information from the various medical providers and healthcare facilities that provide his/her care. The patient's information is then combined into one comprehensive and more complete view of the patient's medical history, called The Patient Summary, for the patient's treating providers to access. The Patient Summary can be accessed and searched by participating QHN providers involved in the patient's care and helps them better understand the patient's medical history in order to provide him/her with better care.

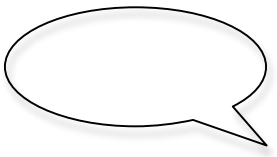
As a parent of _____ , you have the right to prevent your child's medical provider(s) from using QHN to search and view your child's record in the Patient Summary. This right is referred to as "Opt-Out". If you choose to Opt-Out, you understand the following: (1) that your child's medical provider(s) will **NOT** be able to view the patient's medical record as compiled within the Patient Summary, even in the case of an emergency. AND (2) that your child's medical provider(s) will still electronically exchange information (e.g. diagnostic lab, radiology, and other information) needed to provide treatment as permitted under HIPAA Privacy law.

Please initial below if you do not want your child's medical provider(s) to use QHN to search and view his/her medical record.

_____ DO NOT USE QHN to search and view my child's medical record without my prior permission

Initial here

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.



| _____ | _____ | _____ |
|---|---|---|
| **Parent/Guardian PRINTED Name** | **Parent/Guardian Signature** | **Date** |

Revised: 08/10/15