e-BACKPAC

School-based Telehealth Program

STUDENT REGISTRATION

By completing this form, I consent in advance to my child having access to all available services of e-BACKPAC as long as my child remains enrolled in _____Name of School District_____ . 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 an e-BACKPAC provider.

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

DOB:_____ SSN: _____ Age: _____ School: _____Grade: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Other _____

Language: ☐ English ☐ Spanish Other_____

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Other ☐ Don't Know ☐ Choose Not to Disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male (female-to-male) ☐ Transgender Female (male-to-female)

Are you Homeless: ☐ YES ☐ NO If yes, where do you sleep at night? ☐ Shelter ☐ Street ☐ Friend/family Other_____

Mailing Address: _____City: _____ Zip: _____

Primary Phone: _____ Parent Email: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Who does the child live with most of the time? _____

Emergency Contact, (not living at same address) whom we could contact.

Name: _____ Relationship: _____ Ph.: _____

Person Responsible for the Bill: _____

Is the Patient covered by insurance? ☐ YES ☐ NO.

Martinsville-Henry County Coalition for Health and Wellness offers a REDUCED FEE for services.

☐ YES I would like a Reduced fee for Service APPLICATION ☐ NO Thank you I am not interested at this time

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: _____City: _____

Date of last physical: _____ Office where immunizations were completed: _____

Dentist: _____Phone: _____Date of last Visit: _____ Ages 6-9 Dental Sealants : ☐ Yes ☐ No

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

e-BACKPAC

STUDENT REGISTRATION

Child's Name: _____DOB: _____

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. e-BACKPAC 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 e-BACKPAC 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 are available on our websites at **www.healthycommunitymhc.org or www.piedmontcsb.org** and at each school nurse office.

I, the undersigned,

- give permission and consent for my child to have treatment through and by the e-BACKPAC program. 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 e-BACKPAC staff 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 websites www.healthycommunitymhc.org or www.piedmontcsb.org and the school nurse office).
- agree to release all records related to this treatment to the Primary Care Provider
- agree that 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 providers of the e-BACKPAC program.
  - authorize payment of benefits to providers of the e-BACKPAC program 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: _____

Student Health Questionnaire

Students must have parental permission to be seen by an e-BACKPAC provider.

_____ _____ _____
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*
_____

☐ Diabetes
☐ Vision Problems
☐ Hearing Problems
☐ Sickle Cell Anemia
☐ Anxiety/Depression
☐ Asthma - Date of last asthma attack _____
☐ Seizures - *Date of last seizure* _____
☐ Heart Problems - ***Please list*** _____
☐ Bleeding Disorders- ***Please list*** _____
☐ Other Behavioral Health Concerns: (includes ADD/ADHD)_____
☐ Orthopedic (bone or joint) Problems
☐ Operations and/or Hospitalizations - *Dates (details below)* _____
☐ Diseases in Siblings ***Please explain*** _____
☐ 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*_____

Does your child/youth use tobacco? ☐ Yes ☐ No What kind?_____ How much?_____
Does your child/youth drink alcohol? ☐ Yes ☐ No What kind?_____ How much?_____
Does your child/youth exercise daily? ☐ Yes ☐ No?
Does your child/youth have any communication needs? (impaired vision, difficulty hearing, speech disability)
Does your child/youth need assistance in obtaining adequate Housing? ☐ Yes ☐ No
Does your child/youth need assistance in obtaining adequate Food Supply? ☐ Yes ☐ No
Does your child/youth need assistance in obtaining adequate Clothing? ☐ Yes ☐ No

In signing this form, I am stating the following:

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

_____ _____
Parent/Guardian Signature Date

If you would like to speak with our medical provider about any of your child's health, please contact Martinsville Henry County Coalition for Health and Wellness (276) 629-1076 or (276) 956-2233