West Bolivar Consolidated School District /Shaw Family Medical School-Based Clinic

MEDICAL INFORMATION FORM

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN (Please Print)

Child's Name:		MALE:		FEMALE:	
Child's DOB:		Child's SSN:			
Address:		City/State/Zip:			
Home Phone:		Work Phone:			
Cell Phone:		Consent to text regarding appointments: YES		NO	
School:		Grade:			

Emergency Contact Name and Phone Numbers and Relation to Child			
1.		**2.**	

Preferred Pharmacy:	
Parent/Guardian's Name:	
Parent's email address:	

Insurance Information	
Insurance/Medicaid Number:	
Dental Insurance Number:	
Vision Insurance Number	

Private Insurance Information and Parents DOB			
Policy Holder:		Relationship to child:	
Group Number:		Policy Number:	

Additional Information

1. List your child's medication/food allergies.

2. List your child's daily medications (name of medicine, amount, when taken, etc.). *Please include inhalers or nebulizers, average x per week for rescue meds.*

3. Date of child's last dental exam:					
4. Date of Child's last eye exam:					
5. Does child wear glasses:	YES		NO		

6. Please list child's surgical history.

CHILD'S MEDICAL HISTORY

PLEASE CHECK "YES" OR "NO" FOR EACH OF THE FOLLOWING:

	YES	NO		YES	NO
ADD/ADHD			RECURRING STREP THROAT		
ALLERGIES			URINARY TRACT/KIDNEY PROBLEMS		
ASTHMA			VARICELLA		
CANCER			FREQUENT STOMACH ACHES		
DIABETES			PREMATURE DELIVERY		
ECZEMA			PERMANENT PHYSICAL DISABILITY		
FREQUENT HEADACHES/MIGRAINES			CROSSED/LAZY EYES		
HEART MURMUR/DISEASE			EYE DISEASE		
HEARING LOSS			EYE PAIN		
HIV/AIDS			FLOATERS/FLASHES		
INFLAMMATORY BOWEL			BURNING EYES		
JAUNDICE			ITCHY EYES		
LEAD POISONING			MUCOUS DISCHARGE		
MENINGITIS			DROOPY EYELID		
OBESITY			EYE INFECTIONS		
OTITIS MEDIA/EAR PROBLEMS			WATERY/TEARING EYES		
PNEUMONIA			SEIZURES		
SCOLIOSIS			SICKLE CELL		
If you answered **"YES"** to any of the above, please explain:					

CHILD'S *FAMILY* MEDICAL HISTORY

PLEASE CHECK YES OR NO and APPROPRIATE RELATIONSHIP TO CHILD:

			RELATIONSHIP TO CHILD							
	YES	NO	Mom	Dad	Grandma	Grandpa	Sister	Brother	Aunt	Uncle
HEART DISEASE										
HIGH BLOOD PRESSURE										
DIABETES										
CANCER										
HIGH CHOLESTEROL										
KIDNEY DISEASE										
ASTHMA										
LUNG DISEASE										
THYROID DISEASE										
LUPUS										
ARTHRITIS										
GLAUCOMA										
CATARACTS										
LAZY/CROSSED EYES										
MACULAR DEGENERATION										
RETINAL DISEASE/DETACHMENT										
PSYCHIATRIC ILLNESSES/MENTAL HEALTH										
DRUG ALCOHOL										

***CHILD'S MENTAL* HEALTH** HISTORY

PLEASE CHECK "YES" OR "NO" FOR EACH OF THE FOLLOWING:

	YES	NO		YES	NO
IMPULSIVE			INATTENTIVE		
DEFIANT			IRRITABILITY		
ARGUMENTATIVE			ENURESIS (BED WETTING)		
ENCOPRESIS (BOWEL MOVEMENT)			ANGER/RAPE		
SERIOUS LYING			SOCIAL WITHDRAWAL		
SUICIDAL IDEATION (CURRENT)			SUICIDAL IDEATION (PAST)		
SUICIDAL ATTEMPTS (CURRENT)			SUICIDAL INTENT (PAST)		
HOMICIDAL IDEATION (CURRENT)			HOMICIDAL INTENT/IDEATION/ATTEMPTS (PAST)		
HOMICIDAL ATTEMPTS (PAST)			CHANGES IN APPETITE/WEIGHT		
EVIDENCE OF EATING DISORDER			SLEEP PROBLEMS		
SELF MUTILATING			SPECIFIC PHOBIAS		
PANIC			OBSESSIONS/COMPULSIONS		
ANXIETY/ EXCESSIVE WORRY			SOMATIC COMPLAINTS (FOR WHICH NO MEDICAL BASIS ESTABLISHED		
SPECIAL ED. PLACEMENT			PROBLEMS IN SCHOOL		
DIFFICULTY W/PEERS			SUSPENSIONS		
FREQUENT OFFICE REFERRALS			DIFFICULTY W/TEACHERS		
FAILING GRADES			ATTENDANCE		
REPEATED GRADES			CRIMINAL ACTIVITY IN SCHOOL		
FATIGUE/ LOW ENERGY			DECREASED CONCENTRATION		

If you answered **"YES"** to any of the above, please explain:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. YOU MAY ALSO HAVE ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.
We are also required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your medical information. Please be aware that HIPAA Compliant Video surveillance is used in non-exam areas at ALL locations.
If you have any objections to this form please speak to the HIPPA Compliance officer for SHAW FAMILY MEDICAL, SMILES ON BROADWAY, NORWOOD FAMILY EYE CARE, LLC, or Tri-sight Counseling Services (the providers). A copy of the privacy policy can be found on each provider's website.

∗Signature: _____

I authorize **SHAW FAMILY MEDICAL** to perform the following procedures on my CHILD;

- EPSDT Screening; which includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education. In addition dental, vision and hearing services are also done.
- **Influenza vaccination (to be given during the peak influenza season)**

*I also authorize **SHAW FAMILY MEDICAL** to file and bill my child's Insurance/Medicaid for Medical services rendered.*

∗Signature of Parent/Legal Guardian: _____ Date: _____

∗Printed Name of Parent/Legal Guardian: _____

I authorize **SMILES ON BROADWAY** to perform the following procedures on my child.

- Dental restorative procedure (fillings) including the use of local anesthesia, mouth prop or employing voice control
- Photographs, x-rays, and molds of teeth
- Removal of baby or permanent teeth
- Treatment of crooked teeth (braces or space maintainers)
- Oral or inhaled medicines (nitrous oxide) to relax the child
- Physical restraint, including holding child or using the papoose board
- Other _____.

The nature and purpose of the procedures have been explained to me in general terms by the SMILES ON BROADWAY staff. Alternative procedures, if any, have also been explained to me, along with their advantages, disadvantages, and risks. I realize that good results are expected, but the possibility and nature of complications cannot be accurately anticipated, therefore, no guarantees, expressed or implied can be given for treatment results.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental procedures, the most common of which include children biting and injuring their tongue or lip following the administration of local anesthesia and soreness around the area being treated. In addition, less common complications include the risk of infection, and swelling.

*I also authorize **SMILES ON BROADWAY** to file and bill my child's Insurance/Medicaid for Dental services rendered.*

∗Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____

I authorize **NORWOOD FAMILY EYE CARE** to perform a complete eye examination for my child with dilation.
Pupil Dilation is a recommended part of our complete eye examination. It allows the doctor to better examine the retina for retinal detachments, holes, tumors, leaking blood vessels, and other retinal problems. Pupil dilation is ***highly recommended*** for ***ALL*** children.
The most common side effect of the eye drops used in the dilation process are light sensitivity and blurred vision *within* arm's length. Distance vision is usually not significantly affected. Sunglasses will be provided. The process is painless and the effects last from 3-6 hours.
*I also authorize **NORWOOD FAMILY EYE CARE** to file and bill my child's Insurance/Medicaid for Eye and Vision services rendered.*

∗Signature of Parent/Legal Guardian: _____ Date: _____

∗Printed Name of Parent/Legal Guardian: _____

I consent to treatment and hereby authorize **TRI-SIGHT COUNSELING SERVICES** to treat (*if medically necessary*) the above mentioned minor and/or child under my legal guardianship. I voluntarily consent to these services when and if applicable:

- Brief Behavioral Health Screenings
- Diagnostic Evaluation
- Psychosocial Assessment
- Treatment Plan Development _____ & Review _____
- Psychotherapy (counseling, talk therapy, psycho-education)
- Individual, group, family, and/or multi-family psychotherapy
- Psychotherapy **with** medication (parent consent first)
- Day Treatment (with prior authorization from insurance)
- Crisis response
- Targeted case management
- Peer support,
- Wraparound facilitation,
- Grant permission to see the child at the school with the school official's signature denoting my consent during school hours,
- Aware of the limits of confidentiality with a minor,
- Freedom of choice in choosing Tri-Sight Counseling,
- Will attend family sessions (via Technology if needed), and
- Permission to file with the insurance company/Medicaid

*I also authorize **TRI-SIGHT COUNSELING SERVICES** to file and bill my child's Insurance/Medicaid for Counseling services rendered.*

∗Signature of Parent/Legal Guardian: _____ Date: _____

∗Printed Name of Parent/Legal Guardian: _____

For Additional information disclosures, policies and privacy notices please see each provider's website:

www.shawfamilymedical.com
www.smilesonbroadwaydental.com
www.norwoodfamilyeyecare.com
www.trisightcounselingservices.facebook.com

Thank you for trusting us with the care and treatment of your child!