Maple Heights City School District

5740 Lawn Avenue • Maple Heights, Ohio 44137 • Phone: (216) 587-6100, Ext. 3001

Dear Parent/Guardian:

Maple Heights City Schools has partnered with Cleveland Clinic Children's to provide the services of a mobile school health clinic for students in the district.

Students can be seen on Wednesdays from 1pm until 4pm (12pm to 3pm for Middle School), alternating weeks between the elementary campus, Middle School and High School. The mobile school health clinic is staffed by a pediatric provider and licensed support staff. It has two exam rooms which allow students to be seen in the mobile unit.

To access services through the mobile school health clinic, parents/guardians must complete a consent packet. Completed packets should be turned in to your school secretary. **Appointments will be made through the Maple Heights District Nurse at 216-905-3902.**

It is important to note that if you have insurance, Cleveland Clinic Children's will bill your insurance for this visit. If your child does not have insurance, a Cleveland Clinic financial counselor will contact you to explore possible assistance options within one week of receipt of the enrollment packet.

Cleveland Clinic Children's will accept new enrollment packets throughout the year for the school based health program. **If you have questions please call 216-442-7242.**

Sincerely,

Dr. Charlie Keenan, Superintendent
Maple Heights City Schools

Cleveland Clinic Children's
School Based Health Center
Mobile Unit Staff

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Health Information Management/Medical Record Department, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

1-844-203-8777
Fax: 216-587-8043

Patient Name: ____

Last 4 Digits of Patient's SSN: ____________________
Date of Birth: __________ / __________ / _________

For the purposes of this form, "my," and "I" mean the patient listed above whose record is maintained by Cleveland Clinic.

I hereby authorize Cleveland Clinic to release any and all health information that is contained in my patient records to the Maple Hts City School District for treatment and as otherwise needed for my safety and education at the sole discretion of Cleveland Clinic. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

Once my health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I agree to this authorization. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization form will automatically expire when Cleveland Clinic is no longer providing school-based health care services to the students of the Maple Hts City School District, when I am no longer a student of Maple Hts City School District, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to: Administrator, Community Pediatrics, Cleveland Clinic Children's, 9500 Euclid Avenue A-11, Cleveland, Ohio 44195.

____ _________ / _________ / _________
Signature of Patient/Patient's Personal Representative** Date Signed
(Student can sign if student is 18yrs or above)

____ ____________________________________
Printed Name Relationship, if not Patient

** Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

* If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **must** accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

School-Based Health Clinic History Form

STUDENT NAME ______________________ **DATE OF BIRTH** ____________

(Please check ✓ all that apply)

ALLERGIES	
❑ **YES**: Please list below ❑ Food: ______________________ ❑ Medications: ______________________ ❑ Insects: ______________________ ❑ Seasonal: ______________________ ❑ Animals: ______________________	❑ **NO KNOWN ALLERGIES**

PAST MEDICAL HISTORY	
❑ Allergies ❑ Asthma ❑ Developmental ❑ Diabetes ❑ Ear Infections ❑ Gastrointestinal	❑ Heart Disease ❑ Neurological ❑ Behavioral: Please list ______________________ ❑ Other: Please list ______________________

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Times per day

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	*Other:* Please list
Alcohol/Drug Abuse	❑	❑	❑	❑	❑	❑	❑	❑	________
Allergies	❑	❑	❑	❑	❑	❑	❑	❑	________
Anxiety	❑	❑	❑	❑	❑	❑	❑	❑	________
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑	________
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	________
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑	________
Cancer-Type?	❑	❑	❑	❑	❑	❑	❑	❑	________
Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	________
COPD	❑	❑	❑	❑	❑	❑	❑	❑	________
Depression	❑	❑	❑	❑	❑	❑	❑	❑	________
Developmental Problems	❑	❑	❑	❑	❑	❑	❑	❑	________
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	________
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑	________
Gastrointestinal	❑	❑	❑	❑	❑	❑	❑	❑	________
Heart	❑	❑	❑	❑	❑	❑	❑	❑	________
Hypertension	❑	❑	❑	❑	❑	❑	❑	❑	________
Osteoporosis	❑	❑	❑	❑	❑	❑	❑	❑	________
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑	❑	________
Psychiatric	❑	❑	❑	❑	❑	❑	❑	❑	________
Seizures	❑	❑	❑	❑	❑	❑	❑	❑	________
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	________
Thyroid	❑	❑	❑	❑	❑	❑	❑	❑	________

PARENT/LEGAL GUARDIAN SIGNATURE
(Student can sign if 18 yrs or older) ______________________ **DATE** ____________

Cleveland Clinic Children's

School-Based Health Center
Student Parental/Court-Appointed Guardian Notice

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Cleveland Clinic Children's School-Based Health Center (CCCSBHC).

Student Name:														**Birth Date:**
School District:														
School:														
Grade:	**Pre K**	**K**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

I acknowledge that my son/daughter/ward named above may receive the following services at the CCCSBHC:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems, etc.)
- Adolescent sexual health screening and Management
- Mental Health Assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Cleveland Clinic will bill your insurance company. Any co-pays will be billed. If you are uninsured, a Cleveland Clinic financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the CCCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School-Based Health Center History Form. Controlled prescriptions will need to be picked up directly from the CCCSBHC mobile unit or the nearest designated Cleveland Clinic Children's physician office.

I certify that I have read this notice and understand its contents.

Signature of Parent/Court-Appointed Guardian: __________________________________ Dated Signed ____________
(Student can sign if student 18 yrs or older)

Relationship to Student: ____________________________

Cleveland Clinic Children's

School-Based Health Center
Student – Demographics

TURN OVER

Section A: Patient Demographics

Student Name:				
Date of Birth: ________/________/_________ Month Date Year		Sex: ❒ Female ❒ Male	Social Security # :	
Address:			City:	
State:	Zip Code:	Home Phone # :	Cell Phone #:	
Preferred Language:		Do you identify as Hispanic? ❒ Yes ❒ No		
Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Multiracial/Multicultural ❒ Native Hawaiian/Pacific Islander ❒ Caucasian ❒ African American ❒ Declined				
Name of Primary Care Physician:				

Section B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card:		
Date of Birth of Insurance Holder: ________/________/_________ Month Date Year	Social Security # of Insurance Holder :	
Insurance Holder's Employer and Address:		
Insurance plan name:	Subscriber ID:	Group Name/Number:
Insurance Company Address:		

Section C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name:____

Phone #:____

Section D: Emergency Contact Information

Name:			
Address:			
City:	State:	Zip Code:	Relationship to patient:
Home Phone # :	Cell Phone #:		Work Phone # :