



Cripple Creek - Victor School District RE-1



# CCV Mountain Health Center School Based Health Center HEALTH INFORMATION AND PERMISSIONS

Student name – last, first \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Sex:  M  F / SSN (if available) \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ or Contact Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip-Code \_\_\_\_\_

Parent/Guardian – last, first \_\_\_\_\_ Race:  Hispanic, non-white  African American  White/Caucasian  
 Native American  Pacif/Hawaiian  Alaskan Native  
 Asian  Other  Unknown

Family Size: \_\_\_\_\_ Language: \_\_\_\_\_ Family Employer/s: \_\_\_\_\_

Are you or a member of your family employed by the Gaming Industry? Yes \_\_\_\_\_ No \_\_\_\_\_  
(Direct employment)

<b>Medicaid:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medicaid # _____
<b>CHP+:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Account # _____ Group # _____ PCP _____
<b>Private Insurance:</b> (Attach Copy of Card Front & Back)	Insurance Name _____	Insurance Type	HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/>
	Insurance Claims Address: _____	Phone Number: _____	
	Policy or Member ID#: _____	Group #: _____	
	Subscriber Name _____	Relationship to Insured _____	
	SSN _____	DOB _____	

Please list any significant health conditions, allergies, medical/physical limitations/restrictions and medications i.e. *asthma, allergies, diabetes, heart condition, including over the counter medications, etc.* \_\_\_\_\_

**By signing this form, I give consent for the aforementioned student to receive necessary and/or advisable health services from staff at the CCV MHC SBHC. I understand the following services will be available but are not inclusive to all services provided:**

*\*Physical exams, immunizations, routine lab tests such as cultures, urinalysis and anemia screening\*Care for acute illness and injury\*Prescription medications such as antibiotics, etc.\*Care for adolescent physical concerns, acne, menstrual problems, and smoking\*Weight, nutrition & physical activity related issues\*Assistance in care of certain chronic conditions such as asthma and seizure disorders\*Drug, alcohol, and tobacco prevention, education, assessment and counseling\*Behavioral health services including individual, family, and group therapy\*Follow-up as requested by family doctor\*Student health education. ALL invasive procedures will require parental presence in the CCV MHC.*

*Cripple Creek-Victor School District RE-1 in overseeing the CCV MHC SBHC has agreed, as permitted by law, to share your student's health information with providers assisting in your student's health care needs including: school psychologist, school counselor, school nurse, as appropriate, and community partner's including: Peak Vista Community Health Center, Pikes Peak Mental Health, Cripple Creek Counseling Center, and therapyworks for treatment, payment, referrals and healthcare operation. This enables us to better address your child's health care needs. Siblings who have a registered student in CCV School District, aged newborn-21 years, are also able to be seen within the CCV MHC.*

PLEASE TURN OVER- SEE OTHER SIDE OF FORM

**PARENTAL CONSENT:** Signing this form gives consent for emergency and routine medical, dental, and behavioral health service treatment of this individual at CCV Mountain Health Center School Based Health Center; a verbal consent will be obtained prior to a student being seen by the medical provider and a parent will always be notified prior to a student being seen by the provider. A yearly passive update of information will be sent home to each registered student of the CCV MHC otherwise this consent will remain in force until my son/daughter leaves school, turns 21 years, or until the consents revoked in writing. As long as the medical, dental, or behavioral health treatment is considered necessary and is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment according to Colorado State age requirements and services will be provided in case of an emergency. However, if prescriptions are needed, there is a procedure that the parent must be notified/present at appointment, for the prescription to be authorized at a pharmacy.

**RELEASE OF INFORMATION:** The information in my son's/daughter's medical record is confidential and will not be released to any unauthorized person or agency without written consent. In conformance with Colorado law guiding all medical facilities, my son or daughter may request that visits and health information remain confidential. For me, or any other party to have access to medical records regarding such information, a written release must be completed by my child. In order for my child to fully benefit from CCV MHC SBHC:

- I authorize the CCV MHC SBHC to disclose all or any portion on my son's/daughter's medical record except for information designated as confidential by my son or daughter, to our family doctor or primary care provider (medical home base) and other CCV MHC staff and school district employees, as necessary for care and treatment and
- The CCV MHC SBHC staff to examine and/or copy my son's/ daughter's school records including Individual Education Plan (IEP), attendance and other records that may assist the staff in helping my son or daughter.

**FEES AND BILLING AUTHORIZATION:** Services available through the CCV MHC SBHC are made possible through the support of a variety of grants and behavioral health agencies. No child will be refused services at the CCV MHC. A \$5.00 donation, per visit, will assist those in need of medication funding.

I authorize the CCV MHC SBHC to disclose all or any portion of my child's medical record to any person or entity performing record keeping or billing services for the CCV MHC, and any person or entities performing billing on behalf of the CCV MHC, verify my or my child's medical insurance coverage or medical care benefits by written or telephone contact with my employer. There are currently some insurance programs that are billed through the CCV MHC.

-I will provide copies of my child's health insurance card and respond to a CCV MHC SBHC representative concerning health insurance information when they call.

\_\_\_\_\_  
Parent / Guardian Signature (unless phone authorization)

\_\_\_\_\_  
Date

X \_\_\_\_\_

X \_\_\_\_\_

**If this is a verbal/phone authorization:** \_\_\_\_\_

2 Signatures of CCV MHC Staff

\_\_\_\_\_  
Printed name/Title of Staff Member

We need your help!! Cripple Creek Victor Mountain Health Center is primarily funded through grants where household size and income of the families being served in the CCV Mountain Health Center may be needed to qualify for future funding. First, please identify the number of people in your family in the chart below. Then determine your total household income and if this is at or below the guideline figures listed below? YES \_\_\_\_\_ NO \_\_\_\_\_

Household Size	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
Household Income	\$38800	\$44350	\$49900	\$55450	\$59900	\$64300	\$68750	\$73200

Thank you for your assistance. This data will help us with seeking additional funding & expansion of programs through the CCV Mountain Health Center