



Cripple Creek - Victor School District RE-1



## Cripple Creek-Victor Mountain Health Center (CCV MHC) School Based Health Center (SBHC) Health Information and Permissions

<i>Student name – last, first</i>	<i>Date of Birth</i>	<i>Grade</i>
<i>SSN (if available)</i>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	/ /
<i>Address</i>	<i>City</i>	<i>State</i>
<i>Parent/Guardian – last, first</i>	<i>Home Phone</i>	<i>Cell Phone</i>
<i>Family Size: _____</i>	<i>Language: _____</i>	<i>Family Employer/s: _____</i>

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

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

<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> (Must Attach Copy of Card Front & Back)	Insurance Name _____		Insurance Type HMO PPO POS
	Insurance Claims Address: _____		Phone Number: _____
	Policy or Member ID#: _____		Group #: _____
	Subscriber Name _____		Relationship to Insured _____
	SSN _____		DOB _____

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. 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 cessation\*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\*For younger children, ALL invasive procedures will require parental presence in the CCV MHC.*

PLEASE TURN OVER AND FILL OUT BOTH FRONT AND BACK OF ALL SHEETS

*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 consultant/Coordinator, as appropriate, and community partner's including: Peak Vista Community Health Center, Cripple Creek Counseling Center, therapyworks and Aspen Pointe 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.*

**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, in most instances, and a parent will be notified prior to a student being seen by the provider. A yearly update of medical information and registration will be needed for each registered student of the CCV MHC. 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/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*
- 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 or on behalf of the CCV MHC, verify my insurance 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 household/ family, and then determine your total monthly household income. Thank you for your assistance. This data will help us with seeking additional funding & expansion of programs through the CCV Mountain Health Center*

Household Size/Number in family \_\_\_\_\_

Household Monthly Income \$ \_\_\_\_\_

*Would you like to be contacted about Medicaid and/or State Children's Health Insurance Program (SCHIP) for health insurance for your child? Yes \_\_\_\_\_ No \_\_\_\_\_*