OMAHA PUBLIC SCHOOLS
School Based Health Services Enrollment and Consent Form
Enrollment is OPTIONAL

2024-25

Student Information

Student Last Name (legal): Student Number:

First Name (legal): Student Middle Name (full):

Gender: ☐ M / ☐ F Birth Date (mm/dd/yyyy): / /

Home Address: City: Zip:

Grade: Name of School Attending:

Parent/Guardian

Parent Last Name (legal): Parent First Name (legal):

Parent Middle Name (full): Parent Birthdate (mm/dd/yyyy):

Parent/Legal Guardian: ☐ Yes ☐ No Relationship to Student:

Home Phone: Work Phone: Cell Phone:

Email: May we text your cell phone number? ☐ Yes ☐ No

School Based Health Services

School-based health services (SBHS) will be available at your child's school or a nearby school. These services will be provided by OneWorld Community Health Centers (OWCHC), Charles Drew Health Center (CDHC), UNMC, Creighton University (Creighton), Children's Hospital & Medical Center (Children's) or other contracted service providers. The school nurse will coordinate care with the school-based health service providers once your child is enrolled.

SBHS will coordinate care with your child's primary care provider, dentist, optometrist/ophthalmologist and/or behavioral health provider. If you have private health insurance or Medicaid, SBHS providers will bill your insurance carrier for services provided. If you do not have health insurance, the SBHS provider will assist families with enrollment in Medicaid, if eligible.

School Based Health Centers

School Based Health Centers (SBHC): ability to screen health status, test for, diagnose and treat common conditions, e.g., sore throats, minor injuries, headaches, immunizations, ear infections, and diseases such as hepatitis, tuberculosis, and sexually transmitted diseases. Nebraska state law allows students to choose whether a parent will be notified of a student's care related to sexually transmitted infections. The SBHC will not provide emergency services. The SBHC may provide behavioral and/or psychiatric services and may also include the use of telehealth technology.

To enroll your child in SBHC and allow OPS to give SBHC staff confidential information for diagnosis and treatment, a signed enrollment and consent form must be on file with OPS and the SBHC provider. The SBHC staff will attempt to contact you regarding your child's visit and services provided.

By signing this enrollment and consent form, you consent to the following:

- ***I authorize*** OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child with school-based health services, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS staff, including the school nurse, to release the following student information to the School Based Health Centers identified above so that they can provide services and conduct program evaluation: family and emergency contact information, state student number, attendance and disciplinary records, schedule, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and information regarding any health condition, such as seizures, allergies, concussions or asthma.

Dental Services

Dental Services: Where required by law, OPS provides dental screening services conducted by parties contracting with OPS. Services may include oral health education, screenings, fluoride varnish application, preventative care/cleaning, restorative/corrective care, and use of telehealth technology. OPS may provide dental screenings in addition to those required by law. By signing this consent form, you consent to the following:

- ***I authorize*** UNMC, OWCHC, CDHC, Creighton and/or other contracted provider to examine and treat my child with dental screenings and follow-up treatment, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS staff, including the school nurse, to release the following student information to the identified dental service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of dental screenings.

Vision Services

Vision Services: Where required by law, OPS provides vision screening services conducted by parties contracting with OPS. OPS may provide vision screening services in addition to those required by law. Services may include screening, examination, treatment, and/or corrections such as eyeglasses, and may include telehealth. By signing this consent form, you consent the following:

- ***I authorize*** Children's and/or other contracted providers to examine and treat my child with vision screenings (where OPS is not required by law to provide the screenings) and exams, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- ***I authorize*** OPS including the school nurse, to release the following student information to the identified vision service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of vision screenings and exams.

This authorization expires when my child leaves OPS or graduates. I understand that I may revoke this authorization at any time by submitting a letter to the Omaha Public Schools, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024 or by checking the box to revoke below.

School Based Health Centers	◯ **No**	◯ **Yes**	I authorize OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child as described above. I further authorize OPS to release information as described above.
Dental Services	◯ **No**	◯ **Yes**	I authorize my child to receive dental services through UNMC, OWCHC, CDHC and/or Creighton. I further authorize OPS to release information as described above.
Vision Services	◯ **No**	◯ **Yes**	I authorize my child to receive vision services through Children's and/or other contracted service providers as described above. I further authorize OPS to release information as described above.

Parent/Guardian Signature | Relationship to Child | Date

Omaha Public Schools does not discriminate on the basis of race, color, national origin, religion, sex (including pregnancy), marital status, sexual orientation, disability, age, genetic information, gender identity, gender expression, citizenship status, veteran status, political affiliation or economic status in its programs, activities and employment and provides equal access to the Boy Scouts and other designated youth groups. The following individual has been designated to accept allegations regarding non-discrimination policies: Superintendent of Schools, 3215 Cuming Street, Omaha, NE 68131 (531-299-9822). The following persons have been designated to handle inquiries regarding the non-discrimination policies: Director of Equity and Diversity (equityanddiversity@ops.org), 3215 Cuming St, Omaha, NE 68131 (531-299-0307).

Office Use Only: ☐ Verified ☐ Programs ☐ Sections Initials

Charles Drew HEALTH CENTER, INC.
"Growing a Healthy Community"

This Box for Staff Use Only:
Careful Contact: ☐ Yes ☐ No
School-Based: ☐ Yes ☐ No
Barrier: _____

SCHOOL BASED HEALTH SERVICES (SBHS) PATIENT REGISTRATION, CONSENT TO TREAT, & HEALTH HISTORY FORMS

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

PART I: PATIENT REGISTRATION

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

Email Address: _____

Please check which of the following best describes your race. Please only select one:

☐ American Indian or Native Alaskan
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ More than one race
☐ Unknown, not listed, or refuse to report

Please check which of the following best describes your ethnicity. Please only select one:

☐ Hispanic, Latino, or Chicano
☐ Non-Hispanic, Latino, or Chicano
☐ Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

☐ Medicaid
☐ Medicare
☐ Private or commercial insurance (including through Marketplace)
☐ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size	Annual Income Ranges					
1	☐ $0-$15,060	☐ $15,061-$18,825	☐ $18,826-$22,590	☐ $22,591-$26,355	☐ $26,356-$30,120	☐ Over $30,121
2	☐ $0-$20,440	☐ $20,441-$25,550	☐ $25,551-$30,660	☐ $30,661-$35,770	☐ $35,771-$40,880	☐ Over $40,881
3	☐ $0-$25,820	☐ $25,821-$32,275	☐ $32,276-$38,730	☐ $38,731-$45,185	☐ $45,186-$51,640	☐ Over $51,641
4	☐ $0-$31,200	☐ $31,201-$39,000	☐ $39,001-$46,800	☐ $46,801-$54,600	☐ $54,601-$62,400	☐ Over $62,401
5	☐ $0-$36,580	☐ $36,581-$45,725	☐ $45,726-$54,870	☐ $54,871-$64,015	☐ $64,016-$73,160	☐ Over $73,161
6	☐ $0-$41,960	☐ $41,961-$52,450	☐ $52,451-$62,940	☐ $62,941-$73,430	☐ $73,431-$83,920	☐ Over $83,921
7	☐ $0-$47,340	☐ $47,341-$59,175	☐ $59,176-$71,010	☐ $71,011-$82,845	☐ $82,846-$94,680	☐ Over $94,681
8	☐ $0-$52,720	☐ $52,721-$65,900	☐ $65,901-$79,080	☐ $79,081-$92,260	☐ $92,261-$105,440	☐ Over $105,441

SECTION III: INSURANCE INFORMATION

Insurance Name: _____ Policy number/Enrollment ID: _____

Group ID: _____ Member ID: _____

SECTION IV: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

How did you hear about Charles Drew Health Center, Inc.? _____

SECTION V: FINANCIAL RESPONSIBLE PARTY INFORMATION

Should match insurance card, if applicable. Only complete this section if the responsible party is different from patient.

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Cell Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

☐ Alt. Phone: _____ May we leave a voicemail? ☐ Yes ☐ No

Email Address: _____

Preferred Language: _____ Interpreter Needed?: ☐ Yes ☐ No

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

PART 2: CONSENT TO TREAT

1. **Authorization for Medical Treatment.** I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment, as deemed necessary by Charles Drew Health Center, Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center, Inc. facility will follow the instructions of my provider(s) in the position in said care.
2. **Patient Care.** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.
3. **Personal Valuables.** I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center, Inc. maintains no responsibility for property that is personal and in my possession.
4. **Duration and Scope.** I understand this agreement will be valid for one year (12 months) from the date it is signed, unless I cancel it sooner. This agreement will apply to any care provided to the patient at any Charles Drew Health Center Inc. locations during the next year, unless the care provided requires additional consents by law.
5. **Physician and Staff Employment.** Some providers at Charles Drew Health Center Inc. may be independent contractors who use Charles Drew Health Center Inc. facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill Charles Drew Health Center Inc. may submit. Contractors are responsible for their own actions and Charles Drew Health Center Inc. is not liable for their actions or failure to act.
6. **Assignment of Facility Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Charles Drew Health Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicare and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.
7. **Assignment of Professional Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to all physician(s), therapist(s), and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.
8. **Authorized Representative.** I hereby authorize Charles Drew Health Center Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).
9. **Statement of Responsibility.** I understand that I am financially responsible to Charles Drew Health Center Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.
10. **Sliding Fee Discount Program Policy.** Charles Drew Health Center Inc. has a sliding fee discount program and I may ask about it at any time. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request a sliding fee application at any time.
11. **Self-Payment.** I understand I may choose to not have Charles Drew Health Center Inc. bill my and/or the patient's insurance for a particular health care item or service provided to the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify Charles Drew Health Center Inc. in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.
12. **Authorization to Release Information to Insurance Company/Third Party Payer.** I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. This Facility will endeavor to protect the confidentiality of my medical records. However, the Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed.
13. **Non-covered Medicare/Medicaid Services.** The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

14. **Shadowing and Observation.** Some people involved in patient's care may be medical, nursing, or other health care personnel in training. I consent to their participation. Other non-Charles Drew Health Center Inc. staff members may observe the patient's care. I have the right to request that any of these individuals not participate in or observe the patient's care and this request will not affect the patient's care at Charles Drew Health Center Inc.

15. **Contact by Phone.** By providing Charles Drew Health Center Inc. with my land line and/or cell phone number(s), I give my express consent for Charles Drew Health Center Inc., its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages regarding accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

16. **Advanced Instructions for Healthcare.** I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Patient Rights and Responsibilities.

_____ *Please Initial.* I acknowledge notification of Charles Drew Health Center, Inc. Privacy Practices.

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Parent/Power of Attorney/Guardian Signature: _____ Date: _____

Responsible Party's Signature *(if not the same as patient/parent)*: _____

Insured's Signature: _____ Witness to Signature: _____

Patient unable to sign consent because: _____

PART 3: HEALTH HISTORY

SECTION I: PATIENT MEDICAL HISTORY

Does your child have allergies? ☐ Yes ☐ No

If yes, what?

Is your child taking medicine? ☐ Yes ☐ No

If yes, which ones?

Were there any problems with the pregnancy or birth of your child? ☐ Yes ☐ No

If yes, what were they?

Any serious injuries or accidents? ☐ Yes ☐ No

If yes, what are they?

Have you taken your child to the hospital recently? ☐ Yes ☐ No

Where? _____

Date? _____

Has your child been to clinics or urgent care centers for any health problems recently? ☐ Yes ☐ No

Where? _____

Date? _____

Does your child have any serious illnesses or medical conditions (like asthma, diabetes, anemia or infections)? ☐ Yes ☐ No

If yes, what are they?

Has your child ever spent the night in the hospital? ☐ Yes ☐ No

Where? _____

For what? _____

Has your child ever had surgery? ☐ Yes ☐ No

Where? _____

For what? _____

Which of the following illnesses has your child had?

Asthma	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Fainting or almost passing out	☐ Yes	☐ No
Eye problems	☐ Yes	☐ No	Head injury/concussion	☐ Yes	☐ No
Ear infections	☐ Yes	☐ No	Immune problems *(HIV, AIDS, etc.)*	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Tuberculosis *(Active or LTBI)*	☐ Yes	☐ No	ETOH/Drug abuse	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Sprains/strains/broken bones	☐ Yes	☐ No
Chest pain or pressure	☐ Yes	☐ No	Any special testing like x-rays, MRIs	☐ Yes	☐ No
Liver disease *(Hepatitis)*	☐ Yes	☐ No	Mental health issues	☐ Yes	☐ No
Gastrointestinal problems *(GERDS, MSPI)*	☐ Yes	☐ No	Other, please explain:		
Urine infections	☐ Yes	☐ No			

SECTION II: FAMILY INFORMATION

Who currently lives at home? ☐ Mother ☐ Father ☐ Siblings ☐ Other:

Does someone else care for your child? ☐ Yes ☐ No
Example: Daycare/after school care

Does the mother work? ☐ Yes ☐ No

Does anyone in the house smoke? ☐ Yes ☐ No

Family Medical History

Birth defects	☐ Yes	☐ No	Liver disease *(Hepatitis)*	☐ Yes	☐ No
Intellectual disability	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
SIDS	☐ Yes	☐ No	Gastrointestinal problems *(GERDS, MSPI)*	☐ Yes	☐ No
Deafness	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Bleeding disorders	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Immune problems *(HIV, AIDS, etc.)*	☐ Yes	☐ No
Tuberculosis *(Active or LTBI)*	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Sudden death for no reason or from a heart problem	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Mental health issues	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	ETOH/Drug abuse	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Other, please explain:		

SECTION III: GENERAL HEALTH QUESTIONS

Do you have concerns regarding your child's physical, mental, and/or emotional development? ☐ Yes ☐ No
If yes, what are they? _____

Do you have concerns regarding your child's school performance? ☐ Yes ☐ No
If yes, what are they? _____

Is your child involved in special education classes/services? ☐ Yes ☐ No
If yes, what are they? _____

Do you have concerns your child to be in good health? ☐ Yes ☐ No
If no, what are your additional concerns? _____

SECTION IV: PRIMARY CARE PROVIDER AND PHARMACY INFORMATION

Primary Care Provider: _____
Address: _____

Preferred Pharmacy: _____
Address: _____

Any additional providers your child sees regularly?
Provider Name: _____
Address: _____
Provider Name: _____
Address: _____