Sikeston School Based Health Clinic Fact Sheet

School Based Health Clinics (SBHC) are health clinics that bring preventative and immediate care, as well as counseling and health education to children, adolescents, and staff members at schools. By providing these services in the school, children/adolescents may have increased attendance in the classroom, and therefore have more time for learning.

Overview of SBHC

Hours and Coverage: The SBHC is open when school is in session. The Hours of Operation are 7:30am – 5:00pm Monday-Thursday and 8:00am - 12:00pm on Friday. Although appointments are preferred, students and staff members may be seen on a walk-in basis, depending on the problem and availability of staff. If necessary, appointments are available before or after school. If a student or parent does not have a primary care provider, he/she will have phone access to health care providers during the evening, weekends, and vacation by dialing a SEMO Health Network office number. A recorded message will direct the caller to our After-Hours service who is able to reach our provider on call.

Staffing: The staff at SEMO Health Network's SBHC are highly qualified and experienced in providing health care to young people. Our Family Nurse Practitioner and Licensed Clinical Social Worker work in collaboration with a team of physicians and are qualified to diagnose and treat a variety of healthcare needs. Our Family Nurse Practitioner can prescribe medications as needed. The SBHC staff work with, but do not replace your family doctor or school nurse. If you do not have a family doctor, SEMO Health Network would be happy for you to become an established medical or behavioral health patient.

Billing and Costs: No student will be denied access to health care services due to inability to pay at the time of service. As in any health center, there may be a charge depending on the service provided and the parents/guardians or the child's insurance will be billed for the treatment and will be responsible for payment. Patients/parents are responsible for insurance copays and unmet deductibles. Students eligible for the free/reduced lunch program may qualify for Medicaid. If a child does not have or qualify for insurance, SEMO Health Network has a discount program available for those that qualify. Information about various programs and how to apply is available from the health center staff. The SBHC depends upon the ability to collect payment from your insurance carrier in order to maintain the current hours of operation.

Consent for SEMO Health Network's School Based Health Clinic Services

Student Name: _____ Student Date of Birth: _____

Parent/Guardian Information

Father: _____ Mobile Phone: _____ Work Phone: _____

Mother: _____ Mobile Phone: _____ Work Phone: _____

Guardian: _____ Mobile Phone: _____ Work Phone: _____

Alternative Contact: _____ Phone: _____

I, the parent/guardian of said student, give consent for my child to receive services (including, but not limited to, obtaining health history information, physical examination, treatment, Provider ordered labs, and Provider ordered medication and/or vaccination administration) at SEMO Health Network's SBHC with or without a parent/guardian present. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the SBHC staff with written revocation of this consent.

All healthcare information is confidential. By signing this consent form, you are giving the SBHC, the District School Nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

No student will be denied access to health care services due to inability to pay at the time of service. As in any health center, there may be a charge depending on the service provided and the parent/guardian will be billed for the child's treatment and will be responsible for payment of any charge not covered by insurance. When available, insurance or Medicaid will be billed. I understand and agree that the SBHC may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center are assured. I am the legal guardian of the above-named child. I understand that if guardianship changes, a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

_____ _____

Signature of Parent/Legal Guardian Date

SEMO HEALTH NETWORK

Medical Health History

Food Allergies ____Y _____N type of reaction: _____

Medication Allergies ____Y _____N type of reaction: _____

Latex Allergies ____Y _____N type of reaction: _____

Current Medications (please list the name and dose of the medication):

_____

_____

_____

_____

Pharmacy: _____

Pediatrician/Family Practitioner: _____

Hospital Admissions: Date: _____ Reason: _____

Date: _____ Reason: _____

Surgical History: Date: _____ Reason: _____

Date: _____ Reason: _____

Social History:

Alcohol Use: ____Y _____N if yes, please specify _____

Cigarette Use: ____Y _____N if yes, how many per day? _____

Smokeless Tobacco Use: ____Y _____N

E-cigarette/Vape Use: ____Y _____N

Medical History (Please circle if your child has ever been diagnosed):

ADD/ADHD	AIDS/HIV	Abuse	Allergies
Anemia	Anxiety	Arthritis	Asthma
Autism	Bedwetting	Birth Defects	Bladder Disorder
Kidney Disorder	Blood Disease	Blood Transfusion	Cancer
Heart Disease	Heart Defects	Chicken Pox	Chronic Ear Infections
Constipation	Depression	Behavior Disorder	Diabetes
Hearing Problems	Eating Disorder	Eczema	Frequent Headaches
Migraines	Muscle Disorder	Joint Disorder	Bone Disorder
Obesity	Seizures	Sickle Cell Disease	Sickle Cell Trait

Other: _____

I HAVE READ AND UNDERSTAND THE ABOVE AND HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT NOT PROVIDING AN ACCURATE HEALTH HISTORY MAY RESULT IN A NEGATIVE HEALTH OUTCOME. IF ANYTHING CHANGES WITH MY CHILD'S MEDICAL HISTORY, I UNDERSTAND THAT IT IS MY RESPONSBILITY TO UPDATE THE SBHC.

_____ _____

Signature of Parent/Legal Guardian Date