Welcome Letter
Grafton-Taylor
School Base Health Center

Dear Student/Parent/Guardian:

Grafton-Taylor School Base Health Center is a unique Centers located in the school, which provides primary care and mental health services to students and faculty during school hours. The goal of the center is to help improve the health and well-being of students and families. Healthy students are more successful in school.

What is Grafton-Taylor School Base Health?

- Our centers are staffed by a Board-Certified Nurse Practitioner, Licensed Clinical Social Worker, and Medical Assistant that are available for your physical and mental health needs.

The purpose of this program is to provide quality healthcare in a friendly setting, at a time that is convenient to the student and family. The SBHC is NOT trying to replace your regular source of healthcare.

What can I do to register?

1. Please fill out the attached forms and return them to your school office or SBHC. The enclosed forms include:
   a. Consent Forms
   b. Health History Questionnaire
   c. We also need a copy of the student's health insurance card

What happens after I register?

- By completing the enclosed forms, the student may be seen at the SBHC during the school day for health concerns or may be called down for a brief visit to obtain basic health information.
- If your child is in elementary school, we ask that a parent/guardian be available by phone if you are unable to attend the appointment with your child. SCHC will always attempt before the visit to call a parent/guardian. SBHC will always follow up with parent/guardian after in some way.
- SBHC will bill your insurance company for the billable services in our centers.
- Over the counter medications will be of NO charge.

How is private health information shared?

Please visit our website, gtchdwv.org for Notice of Privacy Practices or ask the center for a copy.

Thank you,

Please circle the school which your child attends

Anna Jarvis Elementary School  West Taylor Elementary School  Flemington Elementary School
Taylor County Middle School  Grafton High School

THIS IS NOT A MEDICAL RECORD DOCUMENT
General Consent for Healthcare Services,
Notice of Privacy Practices Acknowledgment

Please fill out Patient Information:

Last Name: ____________________________ First: ____________________________ MI: ______
DOB: ____/____/____

General Consent for Healthcare Services

Medical services require a signed consent before services are provided. The following services are available:

- Physical Exams, Sports physical
- Diagnosis and management of acute and chronic illnesses diseases
- Basic laboratory test
- Venipuncture (Blood draws)
- Immunizations
- Health education/risk prevention counseling
- Individual therapy
- Crisis Intervention

Crisis interventions and emergency care do NOT require consent. Life-saving intervention MAY be initiated without prior consent.

We would like to be your partner in the care of your child. Please note that under the West Virginia law, there are some medical care services that your child can have without your permission (consent) of your knowledge. West Virginia law mandates (requires) confidential services to minors in these areas: Pregnancy, Sexually transmitted infections and human immunodeficiency virus (HIV) testing and counseling.

Notice of privacy practice acknowledgement (Check only one)

☐ I have been notified that I can review the Notice of Privacy Practices at gtchd.org or at the SBHC upon my request.
☐ I would like to receive my copy of the Notice of Privacy Practices via US mail
☐ I would like to receive a copy of the Notice of privacy Practices by e-mail at my e-mail address:

If my child is in elementary school, I understand that this consent will remain valid until my child enters Middle school. I will be asked to complete another consent if there is another SBHC at my child’s new school. If the patient is in middle school, it will be valid till child enters high school. I may withdraw my consent for services by writing to SBHC at any time.

I am the patient (18 years or older) or legally authorized representative of the child listed above. I have reviewed and understand the services offered. I give consent to receive the services explained above

_________________________ ____________________________
Date Signed: ____/____/____

Signature of patient or legally authorized representative (if patient is a minor or unable to sign)
Health History Questionnaire

To register your child for the School Base Health Center services please fill out this History form.

Today’s date: _____/____/____  School: ___________________  Grade: ______

Child’s Name: ______________________________________________________

What name does your child like to use? __________________________________

Date of Birth: ________________  Gender: Male  Female

Patient’s address: ______________________________________________________

City: ___________  State: _______  Zip: ________________

Phone number: __________________________  Cell: ______________________

Parent/Guardian Name (if child is under 18): ______________________________

Home phone: __________________________  Cell: ________________________  Work: ______________________

Best way to reach you during school hours ______home, ______cell, ______work

Emergency Contact name if parent is not available: __________________________

Phone __________________________

Do you have health insurance?  Yes  No

Insurance Name: ______________________________________________________

Subscriber Name: __________________________  DOB: _____/____/____

Policy Number: __________________________  Group #: __________________

Does your child have a PCP?  Yes  No  Name of PCP: ______________________

Date of last complete physical: _____/____/____

Preferred Pharmacy: __________________________________________________

Who lives in the home?  Relationship

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________

________________________________________  __________________________
**Health History Questionnaire**

**MEDICATIONS:** ___ My child does not take medication

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dose</th>
<th>reason for taking</th>
<th>how long?</th>
<th>Prescribed by?</th>
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**ALLERGIES:** Does your child have any allergies to medicine, food, insect stings, bites or seasonal allergies? Yes  No (please list below)

|                        |                         |                         |
|------------------------|-------------------------|
|                        |                         |                         |
|                        |                         |                         |

**MEDICAL PROBLEMS:** Please circle all that apply for your child.

- Asthma  
- Depression  
- Learning disability  
- Diabetes  
- Heart problems  
- Anxiety  
- Seizures/Epilepsy  
- ADD/ADHD  
- Other: ____________________________

Does your child wear any of the following (check all that apply)? Eyeglasses  contacts  hearing devices

Has your child ever been hospitalized overnight, had any serious injuries, sports-related injuries, including concussion, or had any type of surgery? No Yes: if yes what age? ______  Problem/Type of surgery?

**FAMILY HISTORY:**

Some health problems are passed from one generation to the next. Have you or any of your child's blood relatives (parents, grandparents, brothers, sisters) living or deceased had any of the listed problems:

___ Unknown family history.  ___ Adopted

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<thead>
<tr>
<th>Problem</th>
<th>Y</th>
<th>N</th>
<th>Relationship</th>
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<tbody>
<tr>
<td>Allergies/asthma</td>
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<td>Cancer (type:</td>
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<td>Depression</td>
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<td>Heart attack or stroke</td>
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<td>before age 50</td>
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<td>High blood pressure</td>
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<td>High cholesterol</td>
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<td>Mental illness/Depression</td>
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<tr>
<td>Migraine headaches</td>
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<td>Smoking</td>
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<td>Substance abuse</td>
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Health History Questionnaire

Other (specify): ________________________________

1. Would you like to schedule an appointment for your child with our Nurse Practitioner or Nurse to discuss any health concerns? Yes No
2. Do you have any questions regarding your child’s weight or eating habits? Yes No
3. Would you like to schedule an appointment with our Clinical Social worker to discuss our child’s emotional well-being or concerns? Yes no
4. Are you concerned about your income meeting the basic needs of your family? Yes No
   A. Do you need additional food for your family? Yes No
   B. Do you need additional clothing for your family? Yes No
   C. Do you need help paying your bills for heat and water? Yes No
   D. Are you concerned about housing for your family? Yes No

If you answered YES to any questions 1-4 above, a member of our staff will contact you.

THANK YOU

__________________________ __/__/__
Print name of person who completed this form Date

Please feel free to call us with any questions. Office (304) 265-1288 or SBHC cell (304)669-3051.

We also have a Facebook page, Grafton-Taylor School Based Health Centers. You can schedule appointments through the Facebook page that is all confidential.

Diana Boyle, BCNP
Era Ford, Medical Assistant

GRAFTON TAYLOR COUNTY HEALTH DEPARTMENT