KEEP

Children's Clinic
School Kidz

1405 Strong Avenue • Greenwood, MS 38930 • 662.459.7030 • www.glh.org

Dear Parent/Guardian:

Greenwood Leflore Hospital's Children's Clinic and your child's school are on a mission to improve the health and well-being of our children. The Children's Clinic pediatricians have partnered with a local dentist and optometrist to provide EPSDT screenings at surrounding schools.

Greenwood Children's Clinic *School Kids* program works in collaboration with the State of Mississippi, Division of Medicaid's EPSDT program, a healthcare program for Mississippi's children ages birth up to 17. The *School Kids* program services include: comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations, laboratory tests including lead toxicity screenings, adolescent counseling, health education, vision, hearing, and dental services.

What does EPSDT stand for?

- **Early -** *Early identification of problems your child may be having*
- **Periodic -** *Checking children's health as recommended for their age*
- **Screening -** *Conducting physical, mental, developmental, dental, hearing, vision, and other screening tests to find potential problems*
  - *After your child's initial vision screening, if a more detailed exam is needed we will refer your child to our partner Dr. Todd Hall or an eye doctor of your choice.*
  - *Depending on your child's age, blood tests will be performed to detect anemia, lead exposure, triglycerides, and RPR.*
- **Diagnosis -** *Performing diagnostic tests or refer your child for testing when a risk is identified*
- **Treatment -** *If problems are found that need to be addressed, we can treat them at the clinic with a follow up visit.*

Why are we dedicated to providing your child this service? We believe routine exams, including dental and vision screenings help millions of children stay healthy, which promotes success in school.

In order for your child or children to receive these exams, the attached forms must be completed and returned to the school as soon as possible.

We look forward to serving your child. If you have questions, please contact our School Kids Coordinator: 662.459.7030.

Sincerely,

The Children's Clinic

School: _____

Grade: _____

Return 1 of 3

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School-Based Wellness Visit Parent Agreement and Consent for Treatment

Child's Name: _____

Birthdate: _____/_____/_____Printed name of Parent/Guardian: _____

Emergency contact number(s): ( ) _____-_____ ( )_____-_____

A. CONSENT FOR TREATMENT: I consent to allow GLH Children's Clinic and its affiliates to furnish medical treatment deemed necessary and appropriate for EPSDT School based screenings outlined in this document.

B. CONSENT FOR USES DISCLOSURES OF HEALTH INFORMATION: I consent to GLH and its affiliates to use and disclose my child's health information for Treatment, Payment and Health Operations. I understand that I may obtain the Notice of Privacy Practices and Patient Grievance Policy which outlines my rights with respect to the uses and disclosure of health information. I may obtain a paper copy from the Children's Clinic's *School Kids* Program Coordinator or an electronic copy at http://www.glh.org/inc/privacyPractices2013.pdf.

C. ASSIGNMENT OF BENEFITS REIMBURSEMENT RIGHTS: I hereby irrevocably assign and transfer payment directly to GLH any benefits payable to me, not to exceed GLH's regular charges, including but not limited to automobile insurance (medical payments, liability, uninsured and underinsured motorist, worker's compensation, homeowner's, premises, produce liability, malpractice, health, hospitalization, Medicare, Medicaid, and applicable benefit, verdict or settlement), and agree GLH has the right to make direct demands to a third party for such payment. I authorize the hospital to obtain any information they deem necessary, including insurance information and accident reports.

D. PROMISE TO PAY: I acknowledge I am responsible for any and all charges incurred, and agree to pay any balance not covered by insurance or hospital benefits programs, including all attorney and/or collection fees and costs necessary to obtain payment of the bill. I also acknowledge GLH has a lien on any claim that may have contributed to medical services rendered, and authorize any insurer or my attorney to apply to GLH directly. I also acknowledge that GLH will be billing for services rendered.

E. MEDICARE/MEDICAID STATEMENT AND CERTIFICATION: If applicable, I certify I am an eligible recipient under the Medicaid Program, Title XIX of the Social Security Act. If applicable, I also certify I am an eligible recipient under the Medicare Program, Title XVIII of the Social Security Act. I understand that if I falsely represent and/or provide false documentation to claim eligibility for Medicare, Medicaid or other government health program benefits, I risk being charged by the government for fraud and if convicted, will be subject to fines and imprisonment.

F. RETIREMENT OF DATA MATTER: I authorize GLH to retire, destroy, or otherwise dispose of x-rays or other data after the customary time span, and to dispose of any medical waste and human tissue in a manner GLH deems appropriate.

G. BY MY SIGNATURE below I certify, as the parent or legal guardian of the student named above, I understand that the EPSDT services will include the following: comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations, laboratory tests including lead toxicity screenings, adolescent counseling, health education, vision, hearing, and dental services.

I acknowledge that all information provided on the Greenwood Leflore Hospital's forms entitled: *School-Based Wellness Visit Parent Agreement and Consent for Treatment, Patient Health Questionnaire* and *Demographic Form* is accurate and complete. I HAVE READ THIS FORM CAREFULLY AND I UNDERSTAND THAT IF I HAVE ANY QUESTIONS I MAY CALL THE GREENWOOD CHILDREN'S CLINIC *SCHOOL KIDS* PROGRAM COORDINATOR AT 662.459.7030 FOR ANY EXPLANATION(S) BEFORE I SIGN THIS AUTHORIZATION.

X _____/_____/_____

Signature of Parent/Guardian Date

Return 1 of 3

Parental Consent

Student Name: _____

Birthdate: _____ SSN: _____ Sex: ☐ Male ☐ Female

PARENTAL CONSENT FOR DENTAL EXAMINATION

Todd Fincher, DDS
113 East Market Street
Greenwood, MS 38930
662.453.1708

Child's Dental Information:

Does your child have any dental pain? ☐ No ☐ Yes If yes, how long? _____

Please indicate any of the following problems:

___ Discomfort, clicking or popping jaw ___ Lost/broken filling (s) ___ Stained teeth ___ Locking jaw
___ Red, swollen or bleeding gums ___ Teeth grinding ___ Ringing in ears ___ Bad breath
___ Blisters/sores in or around mouth ___ Broken/chipped tooth ___ Loose tooth
___ Other (s): _____

Does your child require pre-medication? ☐ No ☐ Yes If yes, how long? _____

Previous dentist: _____ or ☐ My child has never seen a dentist
Last dental exam date: _____/_____/_____ Last dental x-rays date: _____/_____/_____
Times per day child brushes: _____ Times per day child flosses: _____

Is child allergic to:

___ Latex ___ Penicillin ___Tetracycline ___ Dental anesthetics (Novacaine)
___ Aspirin ___ Food allergies; If yes, please list: _____
___ Other: _____

Does child do any of the following:

___ Thumb/finger suck ___ Tongue thrusting/sucking
___ Mouth breathing ___ Lip sucking/biting

☐ I authorize Todd Fincher, DDS, and his licensed staff to provide my child with dental exams, x-rays, and fluoride. Those services will be billed to your insurance; however you will not be billed for any out of pocket expenses. If the minor is already under the care of a family dentist, please continue your routine to arrange dental care for your minor through your dentist.

☐ I do not want my child to have his/her teeth and mouth examined.

Please note: Dental services will be filed with your insurance; however, if you do not have insurance or your insurance does not pay you will ***NOT*** *be billed for any dental services.*

X _____/_____/_____

Signature of Parent/Guardian Date

Return 2 of 3

Todd Fincher, DDS
113 East Market
Greenwood, MS 38917
662.453.1708

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Todd Hall, OD
Mary Kathryn Wilson, OD
814 West Park Avenue
Greenwood, MS 38930
662.453.5400

Demographic Form

STUDENT/PATIENT INFORMATION

Name of School: _____

Student Name: _____

Mailing Address: _____

Birthdate: _____ SSN: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Parent Cell Phone: _____

Parent's email address: _____

Medicare/Medicaid/MSCAN/CHIPS: _____ Policy #: _____

Name on Card: _____

Date of Birth: _____ SSN: _____

Address: _____

PRIVATE OR SECONDARY Insurance: _____ Policy #: _____

Guarantor/Subscriber Name: _____

Guarantor/Subscriber DOB: _____ Guarantor/Subscriber SSN: _____

Guarantor/Subscriber Address: _____

Pharmacy (Drug Store) Name: _____ City: _____

Primary Care/Referring Provider: _____

X _____/_____/_____

Signature of Parent/Guardian Date

Please complete this entire form. It will be used to update your records for this visit and to allow us to contact you if there are any questions or concerns regarding your care and treatment.

Thank you,
GLH and Participating Providers

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New Patient Health Questionnaire

Child's Name: _____ Date of Birth ____/_____/_____ ☐ Male ☐ Female

List any allergies: _____

_____

List current medications: _____

_____

MOTHER PREGNANCY & HEALTH HISTORY

Mother's age at birth? _____

Did she take any medication other than vitamins and iron?
Yes / No

How many weeks gestation at delivery? _____

Please indicate if mother had any of the following during pregnancy:
☐ HIV ☐ Hepatitis ☐ Group B Strep (GBS) ☐ Chlamydia
☐ Gonorrhea ☐ Herpes ☐ Genital Warts

Baby's Birth History

Was baby born on time? Yes / No

Baby's birth Weight: _____ Length: _____

Did the baby have any trouble starting to breath? Yes / No

Did the baby have any problem while in the hospital
(such as jaundice, infections, other?) Yes / No

If yes, what kind_____

Feeding & Nutrition

Is your child's appetite usually good? Yes / No

If no, is it good now? Yes / No

Any colic or feeding problems? Yes / No

Any foods that disagree with him/her? Yes / No

Breast fed or bottle? _____

If on formula, which one? _____

Does he/she take vitamins? Yes / No

Family Health History *(Please check all that apply)*

	Mother	Father	Sister/ Brother	Grandmother/ Grandfather
Anemia				
Asthma				
Diabetes				
Cancer				
AIDS				
High Blood Pressure				
Heart Trouble				
Tuberculosis				
Mental Illness				
Drug or Alcohol Drugs				
Sickle Cell Anemia				
Seizure Disorder				
Other				

Please see reverse side for more information.

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New Patient Health Questionnaire

Please indicate answers by filling in the blanks, or by checking the appropriate box(es)

CHILD'S HEALTH HISTORY

Development and Behavior

At what age did your child sit alone? _____
At what age did he/she walk alone? _____
Did he/she say any words by the time he/she was 1-½ yr. old?
Yes / No
Any other problems? _____
_____

Safety and Environment

Do you live in a private house, apartment, home? _____
_____
Do you know the temperature of your water? _____
_____
Does your smoke alarm work? Yes / No
Are there smokers in the home? Yes / No
Are there any problems with peeling paint, insects, rats or mice?
Yes / No

Past Medical Visit & Allergy History

Where has your child gone for check-ups until now? _____
_____
Date of last check up? _____
Date of last vision test? _____
Has your child had any allergic reaction to any medications, food, or insect bites? Yes / No
If yes, which one? _____
Recent visit to the ER? Yes / No If yes, Date of ER visit_____
Reason for ER visit _____

Previous Immunizations

Are your child's immunizations up to date: Yes / No
Has she/he had a bad reaction to any immunizations? Yes / No
Which ones :_____
_____

Previous Hospitalizations

Any hospitalization/surgeries or ER visits? Yes / No
If so, please list reason: _____
Date: _____

Previous Medical History

- ☐ Eczema
- ☐ Ear Infection
- ☐ Chicken Pox
- ☐ Anemia
- ☐ Recurrent Cough
- ☐ Heart Murmur or Problems
- ☐ Urination Problems
- ☐ Convulsions/Seizures/Nerve Problems
- ☐ Developmental/Speech Delays
- ☐ Sore Throats
- ☐ Dental Problems: _____
  _____
- ☐ Vision Problems: _____
  _____
- ☐ Other:_____
- ☐ Diarrhea
- ☐ Pneumonia
- ☐ Asthma

Past Surgical History

- ☐ Appendectomy
- ☐ Dental Surgery
- ☐ Tonsillectomy
- ☐ Tubes placement
- ☐ Other:_____
- ☐ Adenoidectomy
- ☐ Inguinal hernia repair
- ☐ Umbilical hernia repair

_____/_____/_____
Signature of Parent/Guardian Date