# CCH Tiger Clinic

1100 C.A. DeVillars Rd. Darien, GA 31305 912-205-3457

Dear Parent (s) or Guardian:

**McIntosh County School System has a School Based Health Center (clinic) located in the Todd Grant Elementary School building.** It is our desire to be available for your children's health care needs. The clinic is a comprehensive Primary Care site which includes the following services when signing this consent form and is open to any student within the McIntosh County School System:

A SIGNED CONSENT WILL ALLOW YOUR CHILD:

- To receive Tylenol for pain and other medications/treatments.
- Treatment for illness (Strep Throat, ear infections, pink eye, influenza, ringworms) or injuries (scrapes, strains and cuts).
- Treatment for asthma attacks, etc.
- Treatment for chronic conditions such as diabetes, ADHD and asthma.
- Receive Well Child Checks (including immunizations, hearing and vision screenings)
- Receive routine School and Sports Physicals
- Receive counseling in regard to nutrition and mental health
- Receive lab Tests and other health related issues

The clinic is a part of several insurance plans including the Medicaid system which includes Peach State, CareSource, Amerigroup and PeachCare for kids. The clinic will also accept private insurance as well. Please be sure to fill in each child's name and complete all the information on the attached form. Signing the consent form does not change your child's doctor but it allows the child to be seen at our School Based Health Center and if your child does not have a doctor, we would love to make this your child's primary care home. If you do not have Medicaid or any type of insurance, we have a sliding fee discount program, based on household size and income. Forms are included in this packet.

Your child(ren) cannot be seen without a signed consent form. Please fill out your form and return it today. We encourage you to use the School Based Health Center to address any of the issues above that your child may have in the furture.

Thanks,
Tiger clinic

# CCH Tiger Clinic
# Consent for Health Services & Transportation

McIntosh County Schools and Coastal Community Health have joined in partnership and developed a comprehensive health clinic within McIntosh County School System at Todd Grant Elementary School. This center is staffed with medical & other ancillary service providers – depending upon the services provided at the service site locations. Our services include diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, routine health physicals, immunizations, counseling, behavioral health, dentistry, health education/promotion, hearing, vision and lab testing and referrals to medical subspecialists and community agencies, treatment of vision services with optometry services. Telehealth services may be utilized to provide care as relevant.

The primary focus of the clinic is to provide quality, accessible health care to the children of McIntosh County in order to impact the children's health, school attendance and academic performance.

I hereby request and authorize that:

Print Student's Name: _____ _____ _____
First Name Middle Initial Last Name Birth Date Sex

Receive any and all health care services available from and deemed necessary by the staff of the Tiger Clinic and their associated provider agencies. These services may include, but are not limited to, such procedures as evaluation and treatment of acute illness and injuries. Consent is also given for referral of care and if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Center and its staff.

The School-Based Health Center encourages each student to involve his/her parent or guardians in health decisions whenever possible. Consent for services is authorized for the length of time the youth is enrolled in McIntosh County School System.

I have read and understand the above information and I give permission for my child's care as described and I consent for my child to be **TRANSPORTED/ACCOMPANIED** to and from center service locations by a school designee. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at (912) 205-3457.

Parent/Guardian Signature: _____ Date: _____

Parent Guardian Name_____ Relationship_____

Parent/Guardian DOB: _____ Email: _____

Mailing Address_____

Home Phone #_____ Cell Phone #_____

Emergency Contact Phone #_____ Emergency Contact Name _____

Pharmacy Name _____ Insurance & Policy # _____

# CCH TIGER CLINIC
# STUDENT HEALTH QUESTIONNAIRE

Child's Name: _____ _____ _____
**Last** **First** **Middle Initial**

Date of Birth: _____ Age: _____ Grade: _____ Race: _____
**Month/Date/Year**

Today's Date: _____ School Name: _____
**Month/Date/Year**

The information you provide is **STRICTLY CONFIDENTIAL.** Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.

## Family Information

| Your Name | How are you related to the above named child? |
|---|---|
| | |

1. With whom does your child live? (Check All That Apply)

   _____ both natural parents _____ stepmother _____ alone

   _____ mother _____ stepfather _____ brother(s)/ages: _____

   _____ father _____ guardian _____ sister(s)/ages: _____

   _____ adoptive parents _____ other (explain) _____

2. Does anyone else take care of your child? □ Yes □ No

   **If yes,** who? _____

3. Does your child have any health problems? □ Yes □ No

   **If yes,** what? _____

4. Where do you take your child when he/she is sick and who is your child's doctor?

   _____

5. Where do you take your child for dental care? _____

6. Does your child have any allergies to any medications? □ Yes □ No

   **If yes,** what? _____ Type of reaction _____

7. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? □ Yes □ No

   **If yes,** what? _____

8. Has your child ever been hospitalized or had surgery? □ Yes □ No

   **If yes,** when? _____ Where? _____ Why? _____

9. Do you have any concerns about your child? □ Yes □ No

   **If yes,** what? _____

10. Are the child's parents: (Please Circle Answer) Married Separated Divorced Non-Married Parents

    **If divorced,** when? _____

11. Do the child's parents work outside the home? □ Yes □ No

    **If yes,** what type of work do they do? Mother _____ Father _____

## Family Medical History

12. Does the child's mother, father, siblings or grandparents have any of the following?

| | | **If yes,** who? | | | **If yes,** who? |
|---|---|---|---|---|---|
| High Blood Pressure | □ Yes □ No | | Learning Problems | □ Yes □ No | |
| Diabetes | □ Yes □ No | | Mental Illness | □ Yes □ No | |
| Lung Problems | □ Yes □ No | | Nerve Problems | □ Yes □ No | |
| Asthma | □ Yes □ No | | Drinking Problems | □ Yes □ No | |
| Heart Problems | □ Yes □ No | | Drug Problems | □ Yes □ No | |
| Cancer | □ Yes □ No | | Other _____ | □ Yes □ No | |
| Miscarriages | □ Yes □ No | | | | |

## Family Health Habits

13. How often does your child use a seatbelt (car seat)? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

14. Does your child ride a bicycle, skateboard or roller blade? □ Yes □ No

**If yes,** how often does he/she use a helmet? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

15. Does your child need information about safety (strangers or unknown adults, matches, etc.)? □ Yes □ No

16. How many hours of sleep does your child get each night? _____ hours.

17. Do you feel that you live in a unsafe place? □ Yes □ No

18. Have there been any major changes in your family such as: (Check All That Apply)

___ moving ___ death of family member ___ violence or serious accident

___ physical, emotional, sexual abuse ___loss of job ___ birth ___ other

19. Do you have a gun at home? □ Yes □ No

**If yes**, is it locked? □ Yes □ No

20. Does anyone in your household smoke? □ Yes □ No

21. Do you currently smoke cigarettes? □ Yes □ No

**If yes,** how many cigarettes do you smoke per day? _____ cigarettes a day

## School History

22. Did/does your child attend preschool? □ Yes □ No

23. Do you have any concerns about your child's school performance? □ Yes □ No

**If yes,** what? _____

24. Do you have any concerns about your child's relationships with teachers? □ Yes □ No

25. Do you have any concerns about your child's relationships with other students? □ Yes □ No

26. Do you have any concerns about your child's relationships with siblings or other family members? □ Yes □ No

27. If over 4 years old, does your child have a best friend? □ Yes □ No

28. Does your child participate in sports/exercise or have hobbies, special interests or talents? □ Yes □ No

**If yes,** what _____ How often? _____ How long? _____

## CHILD'S MEDICAL HISTORY

**NAME**_____ **BIRTHDATE**_____ **TEACHER**_____

### ILLNESS HISTORY

| | |
|---|---|
| Allergies | __Yes__No |
| Allergic to drugs | __Yes__No |
| Anemia | __Yes__No |
| Asthma | __Yes__No |
| Other Respiratory Problems | __Yes__No |
| Stomach Ulcers | __Yes__No |
| Abdominal Pain | __Yes__No |
| Constipation/Diarrhea | __Yes__No |
| Serious Digestive Problems | __Yes__No |
| Chicken Pox Age____ | __Yes__No |
| Ear Problem | __Yes__No |
| Ear Infections | __Yes__No |
| Hearing Aid | __Yes__No |
| Eye Problem | __Yes__No |
| Wears Glasses | __Yes__No |
| Physical/Sexual Abuse | __Yes__No |
| Fainting Spells/Knocked Out | __Yes__No |
| Frequent Sore Throat | __Yes__No |
| Headaches | __Yes__No |
| Heart Murmur | __Yes__No |
| Heart Problems | __Yes__No |
| High Blood Pressure | __Yes__No |
| Thyroid Problems | __Yes__No |
| Diabetes | __Yes__No |
| Hepatitis | __Yes__No |
| Injuries (major) | __Yes__No |
| Musculo-Skeletal Problems | __Yes__No |
| BrokensBones | __Yes__No |
| Problems Walking | __Yes__No |
| Kidney/Urinary Tract Problems | __Yes__No |
| | |
| Frequent Colds | __Yes__No |
| Lung Problems | __Yes__No |
| | |
| Menstration Started Age____ | __Yes__No |
| Menstrual Problems | __Yes__No |
| Premature Birth Weight_____ | __Yes__No |
| Obese | __Yes__No |
| Skin Rashes | __Yes__No |
| Serious Acne | __Yes__No |
| Sickle Cell Disease | __Yes__No |
| Sickle Cell Trait | __Yes__No |
| Other Blood Disorders | __Yes__No |
| Seizures/Epilepsy | __Yes__No |
| Speech Problem | __Yes__No |
| Tuberculosis | __Yes__No |
| Cancer | __Yes__No |
| Other_____ | __Yes__No |

### BEHAVIOR STUDY

| | |
|---|---|
| Eating Problems | __Yes__No |
| Thumb Sucking | __Yes__No |

### BEHAVIOR STUDY (Cont'd)

| | |
|---|---|
| Nightmares | __Yes__No |
| Bedwetting | __Yes__No |
| Discipline Problems | __Yes__No |
| Overactive/Hyperactive | __Yes__No |
| Shy | __Yes__No |
| Sleeping Problems | __Yes__No |
| Slow Development | __Yes__No |
| Learning Disability | __Yes__No |
| Smoker | __Yes__No |
| Alcohol | __Yes__No |
| Inhalants | __Yes__No |
| Other Drugs _____ | __Yes__No |
| Depression | __Yes__No |
| Other Behavior Problems | __Yes__No |
| Other Mental Problems | __Yes__No |
| Other_____ | __Yes__No |

Explain any behavior or mental problems noted _____

_____

_____

**PLEASE LIST ANY PRESENT CONCERNS:**

_____

_____

_____

***Explain any illnesses marked yes:

_____

_____

_____

_____

### DENTAL

| | |
|---|---|
| Dental Problems | __Yes__No |
| Meningitis | __Yes__No |
| AIDS/HIV | __Yes__No |
| Rheutmatic Fever | __Yes__No |
| Hemophilia | __Yes__No |
| Underweight | __Yes__No |

When was your child's last dental visit?

_____

How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? _Yes _No

Has your child had any injury to the teeth or jaws? __Yes __No

Does your child have a finger or thumb sucking habit?

Generallyspeaking, what has been your child's experience with a dentist? __Good __Bad __Very Bad
__No experience (the child's first visit)

# Insurance Information

***Please complete this information below and return the information with your signature to the CCH TIGER CLINIC***

## Child's Information

Child's Legal Name: _____ Date: _____

Phone number: _____ Birth Date: _____ SSN: _____

Address: _____

Covered by an insurance plan? Yes__ No__ If Yes, please fill in the appropriate section below.

## Medicaid Information

Medicaid ID#: _____Member ID#_____

## Private Insurance Information

Insured Parent/Legal Guardian: _____

Birth Date of Card Holder: _____ SSN of Card Holder: _____

Address (if different from child): _____

Place of Employment: _____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ ID Number: _____

From (month/year): _____ To (month/year): _____

**Parent Signature**_____ **Date**_____