Dear Parents,
Welcome back to school! White House Clinics is proud to be part of the Berea Independent Schools community and remains committed to supporting your child's well-being and to providing access to much needed health care services.

Medical Services
Our team includes a registered nurse who is on campus each school day to care for all school nurse needs. Our nurse is also able to connect with a White House Clinics provider for further assessment and diagnosis of a wide range of acute and chronic illnesses. This allows increased choice in scheduling appointments according to your schedule while also allowing greater choice in selecting an individual provider.

Dental Services
We are excited to announce that dental services will be offered in our state-of-the-art mobile dental bus this year. Our mobile dental team, led by Dr. Tina Knopp, will be scheduled at the school multiple days each month, and will offer a much wider range of services including complete exams with x-rays to detect decay and abnormalities, cleanings, application of fluoride, preventative sealants, fillings, and extractions if needed. When seen in our mobile clinic, your child will receive a dental report card letting you know what treatment was provided during the visit and what further dental care is recommended.

Behavioral Health
Behavioral health services will also be provided this year. In-person and telehealth visit options are available to students. **We encourage families to be sensitive to the mental health implications that the previous years may have had on your child(ren).** If you notice your child withdrawing from others, crying more than usual, changes in eating or sleep, outbursts, difficulty completing schoolwork, or other disruptive behaviors, we encourage you to consider scheduling a behavioral health appointment for support in helping your child through this stressful time.

Monitoring your child's growth and development should remain a priority for your family. If your child has not had a well child visit in over a year or visited the dentist in the last six months, we strongly encourage you to schedule this care with your child's provider.

Again, on behalf of the White House Clinics, we are delighted to be a part of this wonderful learning environment and look forward to contributing to the health of the Berea Community School system.

Best Regards,

Stephanie Moore

Stephanie Moore, MPA, CMPE
Chief Executive Officer

Health Services Consent Form Instructions

The attached forms will collect the key pieces of information about your child's health that our team must have to provide school nursing services. The first three pages include information about your child's health history, including serious health conditions, allergies, and medications your child is taking. Additionally, these pages provide our staff with contact information for the parent/guardian or trusted emergency contacts that we can call in the event that your child is sick. The insurance portion should be completed for medical or dental provider-based services to occur. Please note, information regarding school nurse visits and emergency conditions may be shared with the school. The last page of the packet includes the signature consent form. This must be completed for your child to utilize nursing, provider-based services, or dental health services. If you choose to use our provider-based services for medicine, dentistry, or mental health, this record will save you from having to complete additional paperwork if or when your child needs services.

Our goal is to always call the parent or guardian prior to providing any provider-based service, however in past years, we have had difficulty reaching some parents and guardians. At times, this has led to a delay in care for the student. To allow more choice and flexibility we have added an option for the parent/guardian to indicate the level at which they are comfortable proceeding with care if we cannot reach either the parent or emergency contact listed in these forms after multiple attempts.

- Option 1: We will not proceed with any provider-based care without the verbal consent of the parent or guardian.

- Option 2: You are indicating that you are okay with the provider-based visit occurring if we try but are unable to reach you.

In our school clinic we do stock a small quantity of childhood vaccines. These are available if a parent specifically requests that their child receive this in the school clinic. We will not administer any vaccine without the express consent of the parent prior to the visit. This option is offered as a service to families who may face transportation barriers, difficulty in scheduling with a primary care provider, or who may otherwise benefit from the vaccine being administered in the school. Our goal is to provide options to parents in accessing healthcare for their families, but we will not provide that care without obtaining your consent to do so.

Please complete the attached consent form in detail and return it to the school as soon as possible.

Thank you!

White House Clinics

WHITE HOUSE CLINICS

BEREA PIRATES

History and Consent for Health Services

CHILD/STUDENT INFORMATION

Teacher: _____

Child's Full Name: _____

Child's Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Race: _____ ☐ Male ☐ Female

How many live in your home: _____

Street Address: _____

City, State, Zip: _____

SERIOUS HEALTH CONDITIONS

My child has the following life-threatening conditions that may require treatment at school (circle all that apply):

☐ Diabetes ☐ Asthma ☐ Allergies ☐ Seizure ☐ Other: _____

My child uses the following emergency medications/treatments (circle all that apply):

☐ Epi-Pen ☐ Glucagon ☐ Albuterol Inhaler ☐ Nebulizer ☐ Other: _____

ALLERGIES

Peanuts:	☐ Yes	☐ No	Reaction: _____
Bee/Wasp Sting:	☐ Yes	☐ No	Reaction: _____
Medications:	☐ Yes	☐ No	Reaction: _____
Latex:	☐ Yes	☐ No	Reaction: _____
Other:	☐ Yes	☐ No	Reaction: _____

CHILD'S PAST MEDICAL HISTORY

1. Past Medical History:

2. Past Surgical History:

3. Daily Medications:

CHILD'S PAST MEDICAL HISTORY cont.		
4. Does anyone smoke in your child's home?	☐ Yes	☐ No
5. Has your child had a chickenpox vaccination?	☐ Yes	☐ No
6. Does your child have a history of diagnosed chickenpox disease?	☐ Yes	☐ No

DENTAL HEALTH HISTORY

1. Has your child received any dental treatment from White House Clinics before? ☐ Yes ☐ No
2. Does your child drink tap water most of the time? ☐ Yes ☐ No
3. If you do not have city water, please list source (Bottle, well, cistern): _____
4. When was your child's last dental check-up/exam? ____ ____ / ____ ____ ____ ____ (MM/YYYY)

**Please note – if it has been 6 months or less since your child's last exam or cleaning someone from our team will reach out to you prior to scheduling dental services.*

If your child is sick and may need to see a provider for further treatment, we will contact you to let you know what symptoms your child is having and discuss the available options. Our staff will not complete a billable visit without your consent. Please list below the numbers where we can try to reach you regarding your child's health.

PARENT CONTACT INFORMATION			
Mother's Name:		Father's Name:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
EMERGENCY CONTACT INFORMATION			
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	

CHILD'S MEDICAL INSURANCE

Does your child have insurance? ☐ Medical Card ☐ KCHIP ☐ Private ☐ None

Company: _____

Policy Number: _____

Who is your child's primary care provider? _____

CHILD'S DENTAL INSURANCE

Does your child have dental insurance? ☐ Medical Card ☐ KCHIP ☐ Private ☐ None

Company: _____

Policy Number: _____

Who is your child's primary dental provider? _____

CONSENT FOR HEALTH SERVICES & ASSIGNMENT OF BENEFITS

I consent to care, as indicated below by my signature, which may include: screenings, exams, assessments, lab tests, treatments, first aid, over the counter medicine and any other health services given to my child, or me, by staff of this school health clinic. I understand that no guarantees are being made as to the effect of any exam or treatment on myself or my child. I authorize the school health clinic to release health information about my child to his or her primary medical or dental providers. I also understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or K-CHIP, I also authorize the school clinic to release this information to Medicaid/K-CHIP so that the Medicaid/K-CHIP can be billed for visits to the school clinic. I also understand by signing this consent, I acknowledge that I have been provided access to the White House Clinics' Privacy Notice (https://whitehouseclinics.com/patient-forms/privacy-notice/). Paper copies are available upon request in the school nurse's office. This authorization will expire one year from the date of signature.

White House Clinics will provide the services as directed by your choices below. If you do not consent at this time, you will be required to provide consent before your child can receive services. We will always call before delivering any provider-based care; however, we have included an option to see a provider if we cannot reach the parent or guardian. Insurance will be billed for provider-based medical and dental services only.

Please circle yes or no for each service below:

☐ Yes ☐ No School Nurse Care *(ex. cuts and scrapes, over-the-counter medications, etc.)*

☐ Yes ☐ No Provider-Based Care *(ex. strep throat, flu, etc.)* If selecting *yes*, please indicate how you want the nurse to proceed if we are unable to reach you:

- ☐ Option 1: Do not continue with this service unless you have my verbal consent. I understand that this level of care will not be provided unless verbal consent is given by a parent, guardian or persons indicated on this form.
- ☐ Option 2: Continue with this service if you have attempted to contact me but were unable to reach me. I consent to provider-based care if I cannot be reached.

☐ Yes ☐ No Preventative Dental Care *(ex. exam, cleaning, and fluoride)*

☐ Yes ☐ No Dental Treatment *(ex. sealants, fillings, extractions, etc.)*

_____ _____

Signature (Parent, Legal Guardian or Emancipated Student) Date