Get Quality Health Care *AT SCHOOL*



Services:

First Aid, Vision/Hearing/Blood Pressure Screenings, Information, Health Education and Referrals, Diagnosis/Treatment of Acute Illnesses (i.e. sore throats, earaches, etc.), Comprehensive/Well Child Physical Exams, Lab Tests, Prescriptions, Adolescent Immunizations, Tuberculin Skins Tests, Management of Chronic Illnesses (i.e. asthma, etc.)



Chelsey Crutchfield, FNP & Candace Vinson, APRN, FNP-BC

See a provider during school hours

The provider is available to see your child conveniently while school is in session.

And you don't miss work!



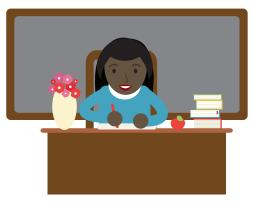
You've got enough to worry about at work. Save the travel time and days off it takes to care for your sick child.

No insurance? No worries!

It's great if you have insurance, but even if you don't, we will help make care for your child affordable through our sliding fee program.



Your child doesn't miss school



Imagine how easy life will be when your child gets medical attention without leaving school.

Valley Health SBHC Huntington High

1 Highlander Way Huntington, WV 25701 304.528.6445

Hours: Monday, Wednesday & Friday: 7:30 a.m. – 3:30 p.m.



VALLEYHEALTH School-Based Health Enrollment Consent Form Name:		Lives with: Father Mother Both Other:				
		Student Da	ate of Birth	Social Security Numb	per Grade	
	llack □Hispanic □Other	Mailing Address				
☐ Asian ☐ American In	dian More than one race	City		 State	Zip Code	
Alaska Nativ	PARENTS/LEGA		ARDIAN		219 0000	
Parent or Legal Guardian Name	<u> </u>	Phone Number (Home or Cell) Phone Number			<u> </u>	
Parent or Legal Guardian Name	Phone Number (Ho	Phone Number (Home or Cell) Phone Number (Wo		ber (Work) Email	ork) Email Address	
Mother Maiden Name	Other Information					
-	her than yourself who have permission			-		
Name: Ph						
INSU HEALTH INSURANCE (Private In:	RANCE INFORM				ALTH INSURANCE	
			, <u> </u>			
Name of Insurance Company	ID Number/Policy Number			Group Number		
Billing Address				Phone Number		
Insurer Name	Insurer SSN		surer Date of B	irth Place of Empl	loyment	
	HEALTH INF	ORMA	TION			
1) Doctor's Name:	Curre	nt Medications	:			
2) Please Check the following services you w Annual Well Child Exam 3) Does your child have any allergies? Please	Immunizations		•			
 Should your child need medication, what phe Pharmacy 				Phone Number		
CONSENT FO	R OVER THE COUN	TER ME	DICATIO	N ADMINISTR	ATION	
No Over the Counter Medication (OTC) will be g School Health Center clinical staff to administe medication will be administered in the course of	r the following OTC medication to my	child as he/she	requests. I and	my child understand that a to	otal of only three OTC	
These are the OTC medications we may admir	nister: Tums (Antacid) Cough Dr	op Ibuprofe	en Hydrocor	tisone Cream 1% Tylend	ol Triple Antibiotic Crean	
Signature of Parent/Guardian		D	ate			
NOTIC	E OF PRIVACY PRAC	CTICES/	PAREN1	TAL CONSENT		
The Valley Health Systems Notice of Privacy Practices are 304-525-3334) office. The Notice of Privacy Practices de of Valley Health Systems healthcare operations and for oth Practices is also posted on the Valley Health Systems webs Privacy Practices. I may obtain a revised Notice of Privacy accessing the Valley Health Systems website at www.valler	escribes the types of uses and disclosures of my er purposes that are permitted or required by la sitie at www.valleyhealth.org. I understand that \ Practices by calling the Valley Health Systems of	protected health in w. It also describes alley Health System	nformation that mig my rights to acces ms reserves the rigi	ght occur for my treatment, payment is and control my protected health in thit to change the privacy practices th	of my bills or in the performance formation. The Notice of Privacy nat are described in the Notice of	
, the parent/guardian of said student, give consent for him and that all healthcare information is confidential. Routine in the student of th	nformation that is part of the school health reco rmation to the school health center. Other inform time by contacting any member of the staff in w	rd may be shared b nation will only be s riting. The health c	y the school health hared with persons enter may release i	center with the county school nurse outside of the health center staff w nformation regarding treatment to the	or designee and the county school ith my or my child's permission, unle nird party payors for billing purposes	
By signing this consent form, (1) you are agreeing to accept responsibilities set out in this form, and (3) are granting Vall or had this form and telehealth consent read and explain to	ey Health permission to bill my insurance for ser	vices provided. I ad	knowledge that I h	ave read this form and the informed		
X			ate			