Medical and behavioral health care services are available to Capital High School students on campus.

Medical care

MONDAY, WEDNESDAY, AND FRIDAY: 8 AM–4 PM

- Regular check-ups and screenings
- Immunizations
- Care when your child is sick or hurt
- Physicals for school, sports, and camp

Behavioral health care

TUESDAY AND THURSDAY: 8 AM–4 PM

- Behavioral health counseling

Just fill out and return the consent form to allow your child to access these health care services.

Questions? Call 304-400-7876.

FamilyCare HEALTH CENTERS

Most insurance accepted, including Medicaid, Medicare, PEIA, CHIP, and Tricare.
Sliding fee scale based on income.

FamilyCare provides health care at the following locations in Charleston:

FamilyCare – Patrick Street

116 Hills Plaza
Charleston, WV 25387-2438

304-720-4466

Children's Medicine Center

800 Pennsylvania Ave.
Charleston, WV 25302-3351

304-414-1880

FamilyCare – Mary C. Snow Elementary

100 Florida Street
Charleston, WV 25302-1131

304-414-4015

FamilyCare HEALTH CENTERS

FamilyCare's qualified providers offer a range of services for every member of the family, every member of the community.

FamilyCareWV.org **FamilyCareWV**

Most insurance accepted, including Medicaid, Medicare, PEIA, CHIP and Tricare. Sliding scale fees based on income. FamilyCare is supported by funds from the US DHHS-HRSA and by funds from the WV DHHR.

FamilyCare HEALTH CENTERS

Business Office
97 Great Teays Blvd., Suite 6
Scott Depot, WV 25560-9816

SCHOOL-BASED HEALTH CENTER CONSENT/ENROLLMENT

Dear Parent and/or Guardian,

FamilyCare Health Centers is pleased to offer school-based health services in your child's school during the school day. Licensed healthcare providers are available at the school to provide expanded medical (treatment for illnesses, injuries, vaccinations and physicals), and behavioral health (individual) on-site and/or by referral. School-based health services work in conjunction with care provided by your child's regular primary care provider (PCP).

All children enrolled in the school-based health program are eligible to receive services regardless of insurance status. FamilyCare Health Centers accepts most insurance plans. Coverage and costs for these services depends upon your insurance coverage. If you do not have insurance, please ask staff about enrolling your child in the WV CHIP program or the FamilyCare Health Centers sliding fee program.

Parents are welcome to accompany their student for scheduled appointments at the health center. For unscheduled acute care visits, we will attempt to notify the parent if a student needs to be seen by a provider. If the parent cannot be reached, the student will be treated and given a note to take to the parents.

Parents are encouraged to actively participate in their child's health care. You are welcome to call or stop by the health center any time. We hope that we can help your child have a healthy and successful school year.

All parts of this Consent/Enrollment form must be completed, signed, and returned to the school before your child can receive services.

CONTACT INFORMATION:

FamilyCare Health Centers
Capital High School
1500 Greenbrier Street-Room 160
Charleston, WV 25311-1007
Phone: 304-400-7876

***Please keep this page for contact information and return the remaining pages to the school.**

Capital High School Health Center
1500 Greenbrier Street, Room 160
Charleston, WV 25311
304-400-7876

Frequently Asked Questions for our Families

What is the Capital High School Health Center?
Capital High School Health Center is a doctor's office located in Capital High School. It is sponsored by FamilyCare Health Centers.

What are the benefits of the school-based health center?
Students can receive health care at the center and return back to learning in their classroom. Additionally, parents do not need to take time off work in order to transport the sick kids to a doctor.

Who can be seen at the Capital High School Health Center?
Students of Capital High School, staff, and faculty.

Who provides care at the Capital High School Health Center?
Dawn Grigsby, APRN, FNP-BC, a Board Certified Family Nurse Practitioner and Derrick Gibson, LPC, a Licensed Professional Counselor, will be at the health center to provide preventive (Checkups and immunizations), acute health care (cold symptoms, sore throat, ear ache, injury, asthma attack, etc.), and behavioral health care to your young children.

What are the services provided at the Capital High School Health Center?

- Primary care
- Behavioral health care
- Diagnosis and treatment of illnesses and injuries
- Physical Exams
- Sports physicals
- Immunizations
- Lab Tests
- Chronic Disease Management such as Asthma and Diabetes
- Referrals

What if the Student already has a doctor?
If your child already has a Primary Care Physician (PCP), we will supplement the care that he or she provides. When necessary, we will communicate with the PCP to assure the best care to your child. If your child does not have a PCP let us know if you would like Dawn Grigsby, APRN, FNP-BC to be your child's PCP.

How is a student enrolled in Capital High School Health Center?

To enroll with us, parents or legal guardians must complete and return the included parental consent.

Can students make appointments during class time?

For routine visits, we work with the school to schedule appointments so students won't miss core classes. For sick visits students are seen as soon as they present to the center.

How would I know about the visit's result?

When your child is seen at the Capital High School Health Center, you will be contacted to discuss the plan of care and answer your questions and concerns. Please make sure that we have your current contact information.

What are the hours of the health center?

Monday-Friday: 8:00AM-4:00PM

Medical Mon/Wed/Fri

Behavioral Health Tues/Thurs

Office closures: Daily – Closed from 12pm-12:30pm; 1st Wednesday – Closes at 1pm for staff meeting; Closed when school is closed.

Do you have walk-in or extended hours for sick visits?

FamilyCare offers walk-in and extended hours at other locations:

FamilyCare – Patrick St. (304) 720-4466		Mon-Thur 5:00PM-7:00PM
FamilyCare – St. Albans (304) 201-1130	Urgent Care Urgent Care Ext. Hours	Mon-Fri 8:30AM-5:00PM Mon-Thur 5:00pm-7:00pm
FamilyCare – Teays Valley (304) 757-6999		Mon-Thur 5:00pm-7:00pm Sat 8:30AM-12:00PM

What about after hours emergencies?

FamilyCare always has a provider on call when the health center is closed, including weekends and holidays. This is for emergencies that cannot wait until the next business day. The answering service can be reached by calling 304-400-7876.

What insurances do you accept?

FamilyCare accepts most Insurance plans, CHIP and Medicaid. The billing department at our Teays Valley location (304-757-6999) can answer any questions you have about insurance. If your child does not have health coverage, ask us for an application for sliding fee, CHIP or Medicaid.

FamilyCare HEALTH CENTERS

Student/Patient Information:

Last Name	First Name		MI
Street Address	City	ST	Zip

Phone #	Other Phone #	Email Address

Sex	DOB	Social Security Number	Ethnicity	Race
			☐ Hispanic ☐ Non-Hispanic	☐ American Indian ☐ Pacific Island ☐ Black ☐ Asian ☐ White

Parent/Guardian	Relationship	DOB	Phone #
1)_____	1)_____	1)_____	1)_____
2)_____	2)_____	2)_____	2)_____

Student Lives With: ☐ Mom ☐ Dad ☐ Both ☐ Other: _____

Name of Emergency Contact	Relationship	Phone #

*** Please Supply a Copy of Insurance Cards (Front and Back) ***

Primary Insurance	Insurance Medicaid Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

Secondary Insurance	Insurance Medicaid Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

Behavioral Health Insurance	Insurance Medicaid Number	Group Number
Insurance Phone Number	Policy Holder Name	
Policy Holder Social Security Number	Policy Holder Date of Birth	Policy Holder Employer

☐ I Do Not Have Insurance Annual Household Income $_____ Number in Household _____

Please check Yes or No after each statement and sign at the bottom	Yes	No
I give permission for my child to be treated by the school-based health staff (including the administration of any over-the-counter medications deemed necessary). A brief health history will be conducted during initial visit with medical provider.	☐	☐
Services may include Medical Services.	☐	☐
Services may include Behavioral Health Services.	☐	☐
I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school based health staff if any of my child's medical history changes.	☐	☐
I have reviewed FamilyCare Health Centers Notice of Privacy Practices (www.familycarewv.org).	☐	☐
Release of Information and Payment Authorization: I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to FamilyCare Health Centers for services provided.	☐	☐
Consent and Acknowledge of Privacy Practices: I consent to the use and disclosure of my protected health information by FamilyCare Health Centers to any person or organization for the purpose of carrying out treatment, obtaining payment, or conducting certain healthcare operations. Protected health information used or disclosed by FamilyCare Health Centers may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with West Virginia and Federal law which may require you to provide specific authorization. I understand that how FamilyCare Health Centers will use and disclose my information can be found in FamilyCare Health Centers Notice of Privacy Practices. I understand that this consent is effective as long as FamilyCare Health Centers maintains my protected health information.	☐	☐
Authorization for Exchange of Health & Education Information: I hereby authorize FamilyCare Health Centers to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable.	☐	☐

Authorization for Exchange of Health Information: I hereby authorize FamilyCare Health Centers to exchange health care records with my child's PCP (Primary Care Provider) for the purpose of continuity of care and treatment of my child, as needed.

My child's Primary Care Provider is: _____

This authorization is valid until I revoke this authorization or until my child no longer attends this school. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. Any changes to parent/guardianship, address/phone number, or any change in medical information is my responsibility to inform FamilyCare Health Centers School Based Center. I recognize that health records if received by the school district may not be protected by the HIPAA Privacy Rules, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I agree that a copy of this authorization is as valid as the original.

The School-Based Health Center staff can provide a copy of the Privacy Notice upon request.

By signing below, I understand and acknowledge the following:

1) I have read and understand this consent.
2) I have reviewed FamilyCare Health Centers Notice of Privacy Practices.

Parent or Legal Guardian Signature	Student Signature (If over 18)
Print Name	Date

Parents are welcome to accompany their student for scheduled appointments at the health center. For unscheduled acute care visits, we will attempt to notify the parent/guardian if a student needs to be seen by a provider. If the parent cannot be reached, the student will be given a note to take home.

Parents are encouraged to actively participate in their child's health care. You are welcome to call or stop by the health center anytime. Our goal is to help your child have a healthy and successful school year.

The Health Center can provide your child with the required immunizations for school along with the recommended immunizations by the Center for Disease Control (CDC). These immunizations can be given, at no cost to you, through the Vaccines for Children's Program (VFC) or billed through your insurance which normally covers preventive services, i.e. immunizations, at 100%.

***** Please send a copy of your child's Immunization Record if you have it *****

Childs Name: _____ DOB: _____

I give permission for the school to share my child's immunization record with the health center for the purpose of updating my child's medical record only. (No immunizations will be given without your permission.)

Yes ☐ No ☐

The Health Center will make every attempt to contact you if your child needs to be sent home. If you are unavailable, who may we contact that has permission to pick them up:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Parent or Legal Guardian Signature: _____ Date: _____

FamilyCare HEALTH CENTERS

STUDENT/PATIENT AND FAMILY MEDICAL HISTORY

STUDENT/PATIENT HEALTH INFORMATION

Student/Patient Name	DOB

Is the Student/Patient allergic to/unable to take or has had a reaction to:	Yes	No
Any foods (including lactose intolerance)		
Any medicines		
Local anesthetics (including lidocaine)		
Latex		

Please explain any allergies:

Is the student/patient taking any medicine now (including inhalers)? If yes, please list:	Yes	No
Has the student/patient ever been hospitalized overnight? If yes, date(s) of hospitalization(s) and reason(s):		
Has the student/patient had any surgery in the past?		
Has there been any change in the student/patient's health during the past year?		
Are any of the student/patient's teeth causing him/her pain?		
Does the student/patient have any heart problems, such as heart murmur or congenital defect?		
Does the student/patient smoke?		
Do the student/patient's gums bleed when brushing or flossing?		
Has student had dental cleaning in the last six months?		
Is the student pregnant or possibly pregnant?		
Is the student/patient nursing?		

Please explain any "YES" answers:

Is there anything that you think our staff should know before treating the student/patient?

FAMILY HISTORY

Have any of the student/patient's blood relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems?

Condition	Yes	No	Condition	Yes	No
Alcoholism/abuse			High blood pressure		
Allergies/asthma			High cholesterol		
Anxiety/depression			Kidney disease		
Birth Defects			Mental retardation		
Blood disorders			Obesity		
Cancer-type:			Seizures/epilepsy		
Diabetes			Sickle cell anemia		
Endocrine/gland disease			Smoking		

Heart attack or stroke: If yes, ☐ before age 55 ☐ after age 55

STUDENT/PATIENT MEDICAL AND DENTAL INFORMATION

Physician Name	Physician Phone #
Dentist Name	**Dentist Phone #**

Has your child seen the dentist in the past year? ☐ Yes ☐ No

Date of Last Physical/Wellness Exam	Date of Last Dental Cleaning
Pharmacy	**Pharmacy Phone #**

Patient History

Has the student/patient had any of the following illnesses or problems?

Condition	Yes	No	Condition	Yes	No
Anemia			Mononucleosis		
Asthma			Overweight/Obesity		
Bladder or Kidney Infections			Rheumatic Fever or Heart Disease		
Chicken Pox			Seizures		
Eating Issues			Sleep Issues		
Headaches/Migraines			Tuberculosis		
Hepatitis			Ulcer/Digestive Problems		
Learning/Developmental Disabilities					

Other health concerns:

STUDENT/PATIENT BEHAVIORAL HEALTH INFORMATION

Has the student/patient ever received counseling or behavioral health services	YES	NO
If yes, please note- Provider name/agency: Dates of service:		

Has the student/patient experienced any of the following behavioral health issues?

ISSUE	YES	NO	ISSUE	YES	NO
Family Changes			Anger Issues		
School Issues			Attention difficulties (ADD/ADHD)		
Social/peer stress			Sadness and/or mood swings		
Anxiety			Truancy/school avoidance		
Learning Disabilities			Recent Loss		

Other behavioral health concerns:

Parent Signature: _____

Date: _____