Jasper School District
School-Based Health Center
Enrollment Form

Student Name: _____ Date of Birth: _____ Grade: _____

Address (Street, Apt, City, State, Zip): _____ Campus: _____

I understand the following types of services may be offered through the School-Based Health Center:

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Treatment of minor injuries
- Vision, Hearing, and medical screenings
- Medical preventative and educational services
- Dental screening, prevention, education and treatment services
- Age appropriate reproductive health services with parent approval (abstinence counseling, education, exams and referrals).*
- Limited immunizations
- Laboratory tests
- Health Education, counseling, and wellness promotion
- Nutrition education and weight management
- Telemedicine
- Prescription medications
- Behavioral Health Services
- Classroom presentations
- Referrals for services not provided by the SBHC

Student needing care will not be turned away due to lack of health insurance or ability to pay, however your insurance may be billed for these services.

Medical services are generally available Monday - Thursday from 7:45 a.m.– 5:15 p.m. and Friday 7:45 a.m. – 11:45 a.m..

I give my permission for the Jasper School District School-Based Health Center to provide medical care, oral health care, illness/infection prevention, wellness promotion programs, and/or behavioral health counseling services to the student named above. ** I agree that the school nurse will provide and receive relevant information to coordinate care and access to services through the SBHC.

I understand that this enrollment form is required for services to be provided along with specific consent forms for Boston Mountain Rural Health Center, Burrell, Chenal and/or Ozark Guidance Services covering services provided by these organizations within the SBHC.

I understand that if my child is in need of unscheduled, acute, non-emergent services, the school nurse/staff will attempt to contact me prior to my child being seen at the SBHC. If a reasonable attempt is made to reach me and I am unable to be reached, I request that the following occur **(check one box)**:

☐ If I am unable to be reached, please **DO NOT** allow my child to be seen at the SBHC.

☐ If I am unable to be reached, **I GIVE MY CONSENT** for my child to be seen at the SBHC.

Parent / Guardian Signature_____

Relationship to Student: _____

Date_____ Phone Number_____

*Arkansas law (Ark.Code Ann.§ 20-9-602 (2012) and § 20-16-508 (2012)) does not require consent for examination and treatment of STDs, examination and diagnosis of pregnancy, family planning services, substance abuse counseling and treatment, and behavioral health counseling and treatment.

**All parental consents must be accompanied by a completed registration form and health history form.