Prisma Health School-based Health Centers

What is School-based Health?

School-based Health refers to medical care provided to students by a Prisma Health Pediatric Nurse Practitioner at their middle or high school. This service is part of OnTrack Greenville's school-based community collaboration to align community resources to keep students on track toward high school graduation and on to post-secondary success.

School-based Health Services offered at OnTrack designated schools are:

- Acute/sick care for headaches, sore throat, ear pain, rash, etc.
- Screenings and follow-ups for depression, anxiety, ADHD, etc.
- Follow-ups in collaboration with our primary care providers and medical specialists for asthma, weight checks, blood pressure checks, etc.
- On-site and telehealth services

OnTrack middle schools: Berea, Lakeview and Tanglewood
OnTrack high schools: Berea and Carolina

If you have questions or want more information, please contact:

Misty Lovell, CPNP, lead Nurse Practitioner, 864-380-8995 or Misty.Lovell@PrismaHealth.org
Ashley Fisher, RMA, Clinical Coordinator, 864-276-1325 or Ashley.Fisher@PrismaHealth.org

PRISMA HEALTH. Children's Hospital

PrismaHealth.org

FE-9432

Prisma Health School-based Health Enrollment Forms

We are excited to offer your child medical care this school year through Prisma Health School-based Health Clinic. A Prisma Health Pediatrician (MD) or Pediatric Nurse Practitioner (PNP) will be present in your child's school at least one day a week. If the Nurse Practitioner is not physically present and your child is sick, he or she can still be seen through telemedicine. Telemedicine allows a nurse and Prisma Health provider to communicate via video equipment while your child is in the health room. A limited exam can be completed and diagnosis and treatment will be provided for your child by the PNP. In order for your child to be seen by the Prisma Health medical provider, in clinic or via telemedicine, you will need to complete the following four forms located in this folder. **Please fill out all highlighted areas on front and back of each of the forms attached.**

- Permission to Treat-UMG
  - Gives the Prisma Health medical provider permission to provide medical care to your child in the School-based Health Center.
- Over the Counter Medication Form
  - Provides information about your child's medication history and allows Prisma Health medical providers to give over the counter medications in clinic if necessary.
- Consent for Release of Education Records and Information
  - Allows the school to share information with the Prisma Health medical team in order to provide your child with the best possible medical care.
- Patient information sheet
  - Provides Prisma Health medical provider with necessary patient demographic and billing information.

If you need any assistance with completion of the above forms contact your school nurse or a member of the School-based Health Center.

Meet our School-based Health Center (SBHC)

Medical Providers

Dr. Blakely Amati Dr. Amati is a Greenville native and feels grateful to be able to serve patients in her hometown. She is a graduate of Greenville Senior High School and went on to complete her undergraduate education at the College of Charleston, medical school at the Medical University of South Carolina, and her pediatric residency at Greenville Health System. She is board-certified in Pediatrics, is the Medical Director of the Bradshaw Institute for Community Child Health & Advocacy, and a Clinical Associate Professor of pediatrics at the University of South Carolina School of Medicine – Greenville.

Misty Lovell, CPNP. Misty's experience as a PNP includes working as a primary care provider in a federally qualified health center and an SBHC in a Chicago suburb. She has been with MUSC in Charleston for the past five years working as part of the child maltreatment team in addition to the pediatric urgent care clinic. Before becoming a nurse practitioner, she was a school nurse for several years. Misty also served as a Peace Corps volunteer in Belize teaching a life skills course to high school students and providing health education outreach in Mayan villages.

PRISMA HEALTH.

General Permission to Treat

Student Name: _____

DOB: _____

School *(circle one)*:

Berea Middle | Tanglewood Middle | Lakeview Middle

Berea High | Carolina High

Emergency Department patients: Patients presenting to the Emergency Department have the right to receive an appropriate medical screening exam performed by a doctor, or other qualified professional, to determine whether they are suffering from an emergency medical condition or are in active labor, and if so, to receive stabilizing treatment (including delivery of a baby including the placenta) within the capabilities of the Prisma Health staff and facilities. Patients have these rights even if they cannot pay for services, do not have health insurance, or are not entitled to Medicare or Medicaid.

I am the patient named above (or the person authorized by law to make decisions for the patient). I give permission for Prisma Health and its physicians, healthcare providers, staff, and outside companies to perform routine hospital and healthcare services as applicable: including blood draws, medications, tissue disposal/donation, examinations, treatments, lab tests, anesthetics, therapy, transportation, evaluation and treatment services, and procedures, as may be necessary in accordance with the judgment of the provider(s), including appropriately supervised students, residents, and telehealth providers. Treatment may be provided by authorized employees of Prisma Health and the University of South Carolina. I acknowledge that no guarantee can be made concerning the results of treatments.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as human immunodeficiency virus (HIV), hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and methicillin-resistant staphylococcus aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my healthcare providers (nurses, technicians, and physicians) if I do not want to be tested for any one or all of these diseases. If I refuse the tests, I will not be tested. However, if I do not refuse these tests, I may be tested, and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the hepatitis B virus, hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the healthcare worker who was exposed.

I understand video cameras may be used in some hospital rooms for observation purposes and additional photographs may be taken for medical purposes.

Unless otherwise discussed with me, I authorize Prisma Health to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at Prisma Health are members of the Prisma Health medical staff, but they may not be employees or agents of Prisma Health. Many providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non- employed, independent providers. I understand that Prisma Health is not responsible for any act or omission by a provider who is not an employee or agent of Prisma Health. I also understand that Prisma Health is a medical teaching institution, and that students and residents may be involved in my care with appropriate required supervision.

PRISMA HEALTH.

General Permission to Treat

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD-PARTY CLAIMS: If I have insurance, I agree to assign to Prisma Health any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers' compensation benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of Prisma Health), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to doctors who are not employed by Prisma Health any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at Prisma Health (such as pathologists and other private doctors). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. In the event a claim for payment submitted by Prisma Health to my insurance carrier or plan administrator is denied, I authorize Prisma Health to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of patients; plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate Prisma Health as my authorized representative and grant to Prisma Health the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

MEDICARE PATIENTS: If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Prisma Health on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of Prisma Health, except for those services, provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I do hereby appoint Prisma Health as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. To the extent not prohibited by law or contract, I hereby authorize Prisma Health to apply any overpayment it receives to any other account for which I am responsible at Prisma Health or its affiliated entities. If there is no other outstanding account(s) for which I am responsible, the payment will be posted to the intended account and a refund of any overpayment will be processed accordingly.

I understand that Prisma Health may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

PRISMA HEALTH.

General Permission to Treat

DISCLOSURE/USE OF HEALTH INFORMATION: Uses and disclosures of my personal and health information are described in the Prisma Health Notice of Privacy Practices (NPP). I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- Directory/Patient door. Unless I inform hospital personnel otherwise, I consent to my name being listed in the hospital directory, along with my location, general condition, and religious preference to allow clergy visits.

NOTIFICATION OF YOUR PRIMARY CARE PROVIDER: Prisma Health recognizes the importance of keeping your primary care provider (PCP) informed in the event of a hospitalization or Emergency Department (ED) encounter.

We participate in federally mandated programs to streamline communication and ensure your records are available to your PCP. At the time of admission, transfer or discharge, an automated electronic notification will be sent to your PCP.

If you do not wish for such notification to be sent during your current hospitalization or ED encounter, call 833-787- 1223 to opt out. Please note that only future automated notifications can be blocked for the current encounter and opting out will not prevent the important sharing of discharge summaries or other clinical information needed to transition your care back to your PCP.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities handout. I acknowledge by signing below that I have received a copy of the Prisma Health Patient Rights and Responsibilities Handout.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto Prisma Health property. Prisma Health reserves the right to search my property and room for dangerous items. I understand that Prisma Health is not responsible for personal property kept in my room including false teeth, glasses, and other prosthetic devices. Prisma Health is NOT responsible for personal property, including money, unless Prisma Health has issued a receipt for safekeeping of the personal property. Prisma Health is a NO SMOKING facility. To ensure safety, I will allow Prisma Health to keep my smoking materials until discharge or may send them home with family or friends. I understand that this policy is strictly enforced.

CONTACTING PATIENTS: I understand that I may be contacted by my provider or Prisma Health and/or Prisma Health entities and its employees and outside contractors including debt collection companies through any contact information that I have provided to my provider, Prisma Health and/or Prisma Health entities for any purposes related to my medical diagnosis, treatment, fundraising, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This also applies to outside independent companies and doctors and their employees who provide services in or for Prisma Health facilities.) I may be contacted in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cellphone, home phone, work phone, text message, email or fax usage for contacts.

PRISMA HEALTH.

General Permission to Treat

I understand that I may be contacted by Prisma Health using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, patient room phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service. I understand that this will allow Prisma Health to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

Contacting by email or text messaging. To help coordinate your care, your provider will send you text messages and emails that include reminders for scheduling and scheduled appointments, recommended tests, and other information to help you manage your health. The messages may come from your provider, Prisma Health or from our partners who are helping to manage your care. The responsibility of scheduling and canceling appointments will still rest with you, but we hope this service will make things easier.

You may be contacted by Prisma Health using email for transmission of notices regarding billing. statements. Such email notices and text messages are unencrypted and are, therefore, considered unsecure communications and will not include information specific to your clinical information, but they may include information that would be of interest to you because of your health condition. When we send text messages, we will never transmit your full name or address in the text message.

If you DO NOT wish to allow contacting in these manners, please notify a Prisma Health team member in the business office/patient access/ registration, respond to the "opt-out" directions in the text message or choose your communication preference in the patient portal.

I understand if I provide my cellphone number, home phone number, work phone number, and email address and do not tell anyone that I do not want to be contacted in the manners described, I am consenting to receive phone calls, text messages and emails for appointment scheduling and other healthcare reminders and information as described above. I will keep my provider informed of my up-to-date mobile number and email address at all times and notify my provider if the mobile number is no longer in my possession.

I understand that even if I do state that I do not wish to be contacted as described above, my provider, Prisma Health or our partners may still contact me by phone call for scheduling and scheduled appointments, recommended tests, and other information to help me manage my health.

HEALTHCARE ASSOCIATED INFECTIONS: Healthcare-associated infections can be a complication of hospitalization. The SC Hospital Infections Disclosure Act, S.C. § 44-7-2410, requires hospitals to monitor and report targeted healthcare-associated infections to the SC Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/

I understand that the practice of medicine and the security of personal or health information is notan exact science and that not all risks can be eliminated and that NO GUARANTEES HAVE BEEN MADE TO ME.

PRISMA HEALTH.

General Permission to Treat

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL FIVE PAGES OF THIS FORM.

Patient Signature or Authorized Representative	Printed Name/Relationship	Date/Time

Witness Signature 1 of Patient Signature	Printed Name	Date/Time

Witness Signature 2 of Patient Signature (For verbal/telephone consent)	Printed Name	Date/Time

PRISMA HEALTH

Patient Information

(please print)

Full legal name: _____ (Last) _____ (First) _____ (Middle) Preferred name: _____

Date of birth: _____ (Month/Day/Complete year) SS#: _____ Veteran: ____Yes ____No ____Unknown

Sex at birth: ☐ Male ☐ Female ☐ Intersex

Gender identity: ☐ Man ☐ Woman ☐ Transwoman ☐ Transman ☐ Nonbinary ☐ Another unlisted

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Primary care physician: _____ Phone number: _____

Preferred pharmacy name: _____ Phone number: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐ Legally separated

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Decline

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (Black) ☐ Hispanic
☐ Biracial ☐ Asian ☐ Other ☐ Unknown

Home address: _____ City: _____ State: _____ ZIP: _____

Mail to address: _____ City: _____ State: _____ ZIP: _____

County: _____ Primary phone: ( ) _____ Alternate phone: ( ) _____

Preferred language: _____ Patient email: _____

Religion: _____ Preferred method of contact: _____

Guarantor information *(If guarantor is self, skip to emergency contact)*

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: _____ (Last) _____ (First) _____ (Middle) Patient relation to guarantor: _____

Primary phone: ( ) _____

Date of birth: _____ SS#: _____ Alternate phone: ( ) _____

Home address: _____ City: _____ State: _____ ZIP: _____ Country: _____

Mail to address *(if different)*: _____ City: _____ State: _____ ZIP: _____ Country: _____

Emergency contact *(Pediatric patients, please list someone other than parent(s)/guardian)*

Primary contact name: _____ Primary phone: ( ) _____

Patient relation to emergency contact: _____ Alternate phone: ( ) _____

Secondary contact name: _____ Primary phone: ( ) _____

Patient relation to emergency contact: _____ Alternate phone: ( ) _____

Employment

Patient employer: _____ Work phone: _____ Ext: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time
☐ Student part time ☐ Retired date _____ ☐ Disabled ☐ Not employed ☐ Unknown

(Pediatric patients only) Parent/Guardian & immediate family information

Parent #1 *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ (Last) _____ (First) _____ (Middle) Nickname: _____

Date of birth: _____ (Month/Day/Complete year)

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Primary phone: _____ Alternate phone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Parent #2 *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ (Last) _____ (First) _____ (Middle) Nickname: _____

Date of birth: _____ (Month/Day/Complete year)

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Primary phone: _____ Alternate phone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Patient name_____ DOB _____

(Pediatric patients only) Brothers, sisters & other family members

Full name	*M or F*	*Date of birth*	*Relationship*	*Lives with child*
				Yes No
				Yes No
				Yes No
				Yes No

☐ **Check here if no insurance. And skip to authorization (below).**

Accident information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of accident:_____ Date of accident:_____ County of accident:_____

Primary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card:_____ **Date of birth:** _____
Month/Day/Complete year

Patient relationship to subscriber:_____ **Sex:** ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Primary phone: _____

Employer: _____ Work phone:_____ Ext. _____

Insurance co. name: _____ Phone:_____

Policy/Cert #:_____ **Group no.:** _____ Effective date: _____

Subscriber Status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time
☐ Student parttime ☐ Retired date _____ ☐ Disabled ☐ Not employed

Secondary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card:_____ **Date of birth:** _____
Month/Day/Complete Year

Patient relationship to subscriber:_____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Primary phone: _____

Employer: _____ Work phone:_____ Ext. _____

Insurance co. name: _____ Phone:_____

Policy/Cert #:_____ **Group no.:** _____ Effective date: _____

Subscriber status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time
☐ Student parttime ☐ Retired date _____ ☐ Disabled ☐ Not employed

Authorization

I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of patient/guardian/guarantor:_____ **Date:**_____

PRISMA HEALTH
Children's Hospital

Student Name _____

Date of Birth _____

School-based Health Center

Parent/Guardian Approval for Administration of Over-the-Counter Medications

I approve the following list of over-the-counter medications to be given to my child by the School-based Health Center staff (if there are any medications you do NOT want your child to receive, please place an "X" over them.)

You will be notified by telephone if your child is seen in the School-based Health Center and receives any medication.

Name of Medication	Use
Artificial tears	Wash out eyes, add moisture to eyes
Tylenol (Acetaminophen)	Pain, fever
Benadryl (Diphenhydramine)	Allergic reaction, allergies
Zyrtec (Cetirizine)	Allergies
Cough syrup (Dextromethorphan)	Cough
Cough drops	Cough
1% Hydrocortisone Cream	Dry, itchy skin; allergic reaction
Motrin/Advil (Ibuprofen)	Pain, fever
Maalox	Acid Reflux
Neosporin	Cuts, scrapes
Lotrimin	Anti-Fungal

My child is currently taking the following medications:

_____

_____

Allergies: _____

Printed Name of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____ Date _____

CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

I understand that the School District of Greenville County will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to representatives of the Prisma Health School-Based Health program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected by the requirements of the FERPA.

The School District of Greenville County "School District" is independent of Prisma Health and is allowing Prisma Health to provide treatment to students during the school day to those students who have authorized such treatment. I agree to hold the School District completely harmless for any injury, harm or loss that occurs during treatment by Prisma Health or that arises out of treatment by Prisma Health, unless such injury, harm, or loss occurs due to the negligence or willful misconduct of the School District or its directors, officers, employees, and agents.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Signature of Parent/Guardian/Surrogate Parent Date