Greater Meridian Health Clinic, Inc.

A

Kemper Family Medical Clinic • Shuqualak-Noxubee Health Center • Winston County Family Medical Center • Oktibbeha Family Medical Center • Scooba Family Medical Clinic • West End TJ Harris • Meridian High SBC

CONSENT FORM

I understand that necessary and advisable health care services will be provided by qualified health care professionals of Greater Meridian Health Clinic , Inc. and that I am eligible to receive these services.

I understand the following services will be available:

- Physical Exams
- Vision/hearing screening and referrals
- EPSDT for children (unclothed)
- Follow up services as requested by Physician or Dentist
- Routine lab test
- Dental screenings, cleanings, and dental referrals
- Nutrition counseling

Patient First Name: _____ **Patient Last Name**: _____

Name of School: _____ **Grade**: _____

Date of Birth:_____ **Patient Social Security**: _____

Address: _____ Patient Email: _____

Address 2: _____

City: _____ ST: ____ Zip Code: _____ Emergency Contact Name: _____

Home Telephone: _____ Emergency Contact Phone: _____

Other Telephone: _____

Marital Status: Divorced ☐ Married ☐ Single ☐ Widowed ☐ Legally Separated ☐	Sexual Orientation: Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Will not disclose ☐
Gender Identity: Male ☐ Female ☐ Transgender ☐ Will Not Disclose ☐	Employment Status: Employed ☐ Unemployed ☐
Race: African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other ☐ _____	Language: English ☐ Russian ☐ Spanish ☐ Indian ☐ Other ☐ _____

Primary Insurance Company: _____ Member ID #: _____ Insurance Group: _____

Insured's Name: _____ Insured's Date of Birth: _____ Insured's Social Security #: _____

Physician's Name: _____ Dentist's Name: _____

HEALTH HISTORY - (VERY IMPORTANT - PLEASE FILL OUT COMPLETELY) Please check if *patient* has or has had the following:

☐ Chicken Pox	☐ Kidney Problems	☐ Heart Problems	☐ Cleft Lip, Palate	☐ Tuberculosis
☐ Frequent Colds	☐ Anemia	☐ Liver Problems	☐ Tonsilitis	☐ High Blood Pressure
☐ Meningitis	☐ Blood Transfusions	☐ Ear Infections	☐ Respiratory Problems	☐ Hepatitis
☐ Seizures	☐ Eye Problems	☐ Diabetes, Hypoglycemia	☐ Artificial Joints, Bones, Implants	☐ Cancer, Tumors, Chemotherapy
☐ Asthma	☐ Hearing Problems	☐ Bleeding Disorder	☐ HIV+, AIDS, ARC	☐ Jaw Problems
☐ Serious Injuries	☐ Speech Problems			☐ Other

Please explain any items checked: _____

_____

Please list regular medications taken: _____

_____

Do you have any allergies to latex, medication(s), or anything else? ☐ No ☐ Yes, Explain: _____

_____

Do you have anyy dental pain/problems? ☐ No ☐ Yes, Explain: _____

_____

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CONSENT FORM - *continued*

FAMILY HEALTH HISTORY - Please use the following abbreviations to identify famly members who have had any of the following illnesses: F = Father **M** = Mother **S** = Sibling (Sister/Brother) **MP** = Mother's Parent **FP** = Father's Parent

___ Heart Disease	___ High Blood Pressure	___ Tuberculosis	___ Cancer	___ Kidney Disease
___ Mental Retardation	___ Stroke	___ Seizures	___ Diabetes	___ Birth Defect
___ Sickle Cell Trait	___ Sickle Cell Disease	___ Asthma	___ Mental Illness	

I give consent for the patient to receive a complete physical examination upon completion of a medical and/or dental history. For the students, I also consent to the exchange of limited health imformation between medical staff and school officials. Other disclosures of a student's health information will be made only under emergency circumstances to protect the health and safety of the patient or other students. This consent form is valid for one year of services via the Greater Meridian Health Clinic Mobile Access to Care Unit.

Patient or Guardian Signature: _____ Date: _____

(Must be signed in order to be seen.)

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C

HIPAA ACKNOWLEDGEMENT FORM

By my signature below, I acknowledge that I have received a Notice of Privacy Practices of Protected Health Information from Greater Meridian Health Clinic, Inc.

Patient Name: _____

Account Number: _____

Patient (or Guardian) Signature: _____

Date: _____

Witness Signature: _____

Date: _____

PATIENT CONTACT INFORMATION

I authorize Greater Meridian Health Clinic, Inc. to release my records and discuss my medical condition with the following person(s):

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Greater Meridian Health Clinic, Inc. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may become subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

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Part 1. Medical History

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

Age: _____ **Gender**: _____

Home Telephone: _____

School: _____

Grade: _____

Sports(s): _____

1.) HAS THE STUDENT EVER:

		CHECK ONE		IF YES, EXPLAIN
a.	Stayed overnight in a hospital?	☐ Yes	☐ No	
b.	Passed out during or after exercise?	☐ Yes	☐ No	
c.	Had chest pain during or after exercise?	☐ Yes	☐ No	
d.	Had a concussion?	☐ Yes	☐ No	
e.	Been knocked out?	☐ Yes	☐ No	
f.	Had surgery?	☐ Yes	☐ No	
g.	Had neck or head injury?	☐ Yes	☐ No	
h.	Become ill from exercising in the heat?	☐ Yes	☐ No	
i.	Had a back or spine injury?	☐ Yes	☐ No	
j.	Had a heart murmur?	☐ Yes	☐ No	
k.	Had high blood pressure?	☐ Yes	☐ No	
l.	Had a heart problem?	☐ Yes	☐ No	
m.	Fainted during exercise?	☐ Yes	☐ No	
n.	Used any medications or supplements to help gain or lose weight?	☐ Yes	☐ No	
o.	Used any medications or supplements to help improve your performance?	☐ Yes	☐ No	

2.) DOES THE STUDENT:

		CHECK ONE		IF YES, EXPLAIN
a.	Take any medications everyday?	☐ Yes	☐ No	
b.	Use an inhaler?	☐ Yes	☐ No	
c.	Wear contact lenses or glasses?	☐ Yes	☐ No	
d.	Use special protective device for sports?	☐ Yes	☐ No	
e.	Wear hearing aid?	☐ Yes	☐ No	
f.	Have allergies?	☐ Yes	☐ No	
g.	Have any chronic illnesses (asthma, diabetes, seizures, etc.)?	☐ Yes	☐ No	
h.	Missing body parts (kidney, lungs, finger, etc.)?	☐ Yes	☐ No	

Part 1. Medical History - *continued*

3.)

		CHECK ONE		IF YES, EXPLAIN
a.	Has the student's father, mother, sister, or brother had heart problems before 50 years of age?	☐ Yes	☐ No	
b.	Has any doctor ever limited the student's athletic participation?	☐ Yes	☐ No	
c.	Has the student ever broken a bone or had a cast placed?	☐ Yes	☐ No	
d.	In the past year has the student had any broken bones, joint injuries, or dislocations?	☐ Yes	☐ No	

The examination performed for this evalluation is limited to identifying conditions that would limit or prevent a student from participating in athletic activities. This is to certify that the responses to the preceding questions are correct.

Parent/Gaurdian Signature: _____ Date: _____

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Part 2. Physical Examination

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

Chart #: _____

Height: _____ **Weight**: _____

Blood Pressure: _____ **Pulse**: _____

Respiration: _____

Vision Right: _____ **Left**: _____

Corrective Lenses: _____

Last menstrual period: _____

		CHECK ONE		ABNORMAL FINDINGS & COMMENTS
1.	Eyes	☐ Normal	☐ Abnormal	
2.	Ears, Nose, & Throat	☐ Normal	☐ Abnormal	
3.	Mouth & Teeth	☐ Normal	☐ Abnormal	
4.	Head & Neck	☐ Normal	☐ Abnormal	
5.	Cardiovascular	☐ Normal	☐ Abnormal	
6.	Chest & Lungs	☐ Normal	☐ Abnormal	
7.	Abdomen	☐ Normal	☐ Abnormal	
8.	Skin	☐ Normal	☐ Abnormal	
9.	Genitalia-Hemia (male)	☐ Normal	☐ Abnormal	
10.	Orthopedic Screening			
	a. Upper Extremities	☐ Normal	☐ Abnormal	
	b. Lower Extremities	☐ Normal	☐ Abnormal	
	c. Spine & Back	☐ Normal	☐ Abnormal	

Part 3. Clearance

I have examined this athlete. From this limited screen of their basic health, I have the following recommendations:

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared due to: _____

Additional comments: _____

_____

_____

Physician Signature: _____ Date: _____

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CRAFFT Screening Questions

Part A:

During the PAST 12 MONTHS, did you:

Do you have concerns about how your child hears?	☐ Yes	☐ No
Do you have concerns about how your child speaks?	☐ Yes	☐ No
Do you have concerns about how your child sees?	☐ Yes	☐ No
Does your child hold objects close when trying to focus?	☐ Yes	☐ No
1. Drink any alcohol (more than a few sips)?	☐ Yes	☐ No
2. Smoke any marijuana or hashish?	☐ Yes	☐ No
3. Use anything else to get high? *Anything else includes illegal drugs, over the counter drugs and presciption drugs, or things that you sniff or huff.*	☐ Yes	☐ No

Part B:

If the patient answered NO to ALL of the questions in Part A, ask only the CAR question. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

1. Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐ Yes	☐ No
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐ Yes	☐ No
3. Do you ever use alcohol or drugs while you are by yourself or ALONE?	☐ Yes	☐ No
4. Do you ever FORGET things you did while using alcohol or drugs?	☐ Yes	☐ No
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐ Yes	☐ No
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐ Yes	☐ No

Patient Health Questionnaire

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed or hopeless.	☐	☐	☐	☐

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Previsit Questionaire - 11-12 Years

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

Age: _____ **Gender**: _____

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

What changes or challenges have there been at home since last year?

_____

_____

Do you live with anyone who uses tobaco or spend time in any place where people smoke? ☐ Yes ☐ No

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Apprearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted Infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car Safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in risky situations ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high??	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ Yes	☐ No	☐ Unsure
	Have you ever been diagnosed with iron deficieency anemia?	☐ Yes	☐ No	☐ Unsure
For Females Only				
Anemia	Do you have excessive menstual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Check off all the items that you feel are true for you.

☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy food, being active, and keeping myself safe.
☐ I feel that I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
☐ I feel that I have at least one friend or a group of friends with whom I am comfortable.
☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
☐ I am able to bounce back from life's disappointments.
☐ I have a sense of hopefulness and self-confidence.
☐ I have become more independent and made more of my own decisions as I have become older.
☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe: _____

_____

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Previsit Questionaire - 13-14 Years

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

Age: _____ **Gender**: _____

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

What changes or challenges have there been at home since last year?

_____

_____

Do you live with anyone who uses tobaco or spend time in any place where people smoke? ☐ Yes ☐ No

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Apprearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted Infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car Safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in risky situations ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high??	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	☐ Yes	☐ No	☐ Unsure
Anemia	Diet includes iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ Yes	☐ No	☐ Unsure
	Have you ever been diagnosed with iron deficieency anemia?	☐ Yes	☐ No	☐ Unsure
For Females Only				
Anemia	Do you have excessive menstual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Check off all the items that you feel are true for you.

☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy food, being active, and keeping myself safe.
☐ I feel that I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
☐ I feel that I have at least one friend or a group of friends with whom I am comfortable.
☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
☐ I am able to bounce back from life's disappointments.
☐ I have a sense of hopefulness and self-confidence.
☐ I have become more independent and made more of my own decisions as I have become older.
☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe: _____

_____

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Previsit Questionaire - 15-17 Years

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth:_____

Age: _____ **Gender**: _____

For us to provide you and your child with the best possible health care, we would like to know how things are going.
Please answer all the questions. Thank you.

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

What changes or challenges have there been at home since last year?

_____

Do you have any special health care needs? ☐ Yes ☐ No ☐ Unsure, describe: _____

_____

Do you live with anyone who uses tobaco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:_____

_____

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)? _____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ How your body is changing ☐ Teeth ☐ Apprearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ Protecting your ears from loud noises
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done ☐ Plans after high school
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable ☐ Keeping a positive attitude
Healthy Behavior Choices	☐ Pregnancy ☐ Sexually transmitted Infections (STIs) ☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Decisions about sex and drugs ☐ How to support friends that don't use alcohol and drugs ☐ How to follow through with decisions you have made about sex, alcohol, and drugs
Violence and Injuries	☐ Car Safety ☐ Using a helmet ☐ Driving rules for new teen drivers ☐ Keeping yourself and your friends safe in risky situations ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Bullying or trouble with other kids

Questions

Vision	Do you ever complain that the blackboard/whiteboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Have you ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Do you hold books close to your eyes to read?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Do you tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Do you have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble following a conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Do you have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Do you find yourself asking people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Do you misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure

Previsit Questionaire - 15-17 Years- *continued*

Questions About Your Child - *continued*

Tuberculosis	Were you born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Have you traveled (had contact with residents populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Have you ever been incarcerated (in jail)?	☐ Yes	☐ No	☐ Unsure
	Are you infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Do you have parents or grandparents who have had a stroke or heart problem before the age 55?	☐ Yes	☐ No	☐ Unsure
	Do you have a parent with an elevated blood cholesterol (240mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Anemia	Diet includes iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ Yes	☐ No	☐ Unsure
	Have you ever been diagnosed with iron deficieency anemia?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Do you now or have you ever used injectable drugs?	☐ Yes	☐ No	☐ Unsure
For Females Only				
Anemia	Do you have excessive menstual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)? (*If no, skip to Growing and Developing*)	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
Cervical Dysplasia	Was your first time having sexual intercourse more than 3 years ago?	☐ Yes	☐ No	☐ Unsure
Pregnancy	Have you been sexually active without using birth control?	☐ Yes	☐ No	☐ Unsure
	Have you been sexually active and had a late or missed period within the last 2 months?	☐ Yes	☐ No	☐ Unsure
For Males Only				
STIs	Have you ever had sex (including intercourse or oral sex)? (*If no, skip to Growing and Developing*)	☐ Yes	☐ No	☐ Unsure
	Have you ever been treated for a sexually transmitted infection?	☐ Yes	☐ No	☐ Unsure
	Are you having unprotected sex with multiple partners?	☐ Yes	☐ No	☐ Unsure
	Have you ever had sex with other men?	☐ Yes	☐ No	☐ Unsure
	Do you trade sex for money or drugs or have sex partners who do?	☐ Yes	☐ No	☐ Unsure
	Have any of your past or current sex partners been infected with HIV, bisexual, or injection drug users?	☐ Yes	☐ No	☐ Unsure

Previsit Questionaire - 15-17 Years - *continued*

Growing and Developing

Check off all the items that you feel are true for you.

☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy food, being active, and keeping myself safe.
☐ I feel that I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
☐ I feel that I have at least one friend or a group of friends with whom I am comfortable.
☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
☐ I am able to bounce back from life's disappointments.
☐ I have a sense of hopefulness and self-confidence.
☐ I have become more independent and made more of my own decisions as I have become older.
☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe: _____
_____