



120 Oak Avenue, Spruce Pine, NC 28777 828.467.8815  
Hours of operation: 8:00 am – 3:00 pm Monday-Friday throughout the school year. Email APPTS@CRHI.org

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ RACE: \_\_\_\_\_ PHONE: \_\_\_\_\_ ETHNICITY: (CIRCLE ONE) HISPANIC NON-HISPANIC

SCHOOL: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

GENDER: MALE FEMALE PHARMACY: \_\_\_\_\_ CITY: \_\_\_\_\_

DENTIST: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_ CITY: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ Date of last physical: \_\_\_\_\_ CITY: \_\_\_\_\_

PATIENT EMAIL ADDRESS: \_\_\_\_\_

DO YOU GIVE CONSENT FOR HEALTH-E-SCHOOLS STAFF TO CALL AND/OR TEXT YOUR CELL PHONE AND LEAVE VOICE MAILS? (PLEASE CIRCLE) YES NO

**STUDENTS ONLY (UNDER 18)**

MOTHER/GUARDIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ (CIRCLE ONE) MOBILE OR HOME

FATHER/GUARDIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ (CIRCLE ONE) MOBILE OR HOME

WHO DOES YOUR CHILD LIVE WITH MOST OF THE TIME? \_\_\_\_\_ DOES YOUR CHILD HAVE INSURANCE: YES NO

PARENT'S EMAIL ADDRESS: \_\_\_\_\_

**ALL PATIENTS**

IN CASE OF AN EMERGENCY, PLEASE LIST ANOTHER PERSON WHOM WE MAY CONTACT (IF A MINOR, PLEASE LIST SOMEONE OUTSIDE OF THE HOME)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ CO-PAY:\$ \_\_\_\_\_

POLICY/ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF SUBSCRIBER: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ CO-PAY:\$ \_\_\_\_\_

POLICY/ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF SUBSCRIBER: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

HIPAA/FERPA: All persons have health issues that must be handled in a confidential manner. Health-e-Schools staff will share confidential information only in the following situations: when it is educationally relevant for a student's academic progress, when necessary to address potential health care needs, to ensure the safety of the patient, other students/staff and/or school personnel, or other situations specified by law. The Health-e-Schools staff may discuss the patient's medication and other health care needs with the appropriate staff members who will administer the student's medication and provide care to the student while the student is at school. Additional detailed information about the Privacy Practices that govern the Health-e-Schools Telemedicine Program is available on our website at [www.crhi.org](http://www.crhi.org) and at each school nurse office.

I, the undersigned, give permission and consent for the above enrolled patient to have treatment and any recommended procedures (e.g. ear lavage, lab tests, etc.) through and by Health-e-Schools. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment. I give permission for Health-e-Schools to receive information from the school about my child's health history if appropriate, as well as insurance and pharmacies. I acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website [www.crhi.org](http://www.crhi.org) or at the school nurse office). I agree to release all records related to this treatment to the Primary Care Provider. I agree that I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility. As the undersigned of the above patient, I authorize the release of any information necessary to process insurance claims for payment of benefits to CRHI for Health-e-Schools. I authorize payment of benefits to CRHI for Health-e-Schools for services rendered. I have provided details of all insurance policies that cover the enrolled patient. The information above is true and complete to the best of my knowledge.

Parent/Guardian, or Adult Patient Signature (circle one)

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



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NAME (First): \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last): \_\_\_\_\_

DOB: \_\_\_\_\_ School: \_\_\_\_\_

**Allergies:** YES NO If yes, please list: \_\_\_\_\_

Please list ALL medications that patient is on, including prescriptions, vitamins and over-the-counter drugs (attach separate page if necessary)

Medication	What do you take it for?	Dosage	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies other than medications (such as peanuts, bee stings, etc.) \_\_\_\_\_

Please mark any of the following conditions or health concerns and describe any marked:

- \_\_\_\_\_ Asthma Date of last asthma attack: \_\_\_\_\_
- \_\_\_\_\_ Seizures Date of last seizure: \_\_\_\_\_
- \_\_\_\_\_ Hearing Problems \_\_\_\_\_
- \_\_\_\_\_ Vision Problems \_\_\_\_\_
- \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_
- \_\_\_\_\_ Heart Problems(explain) \_\_\_\_\_
- \_\_\_\_\_ Bleeding Disorders (explain) \_\_\_\_\_
- \_\_\_\_\_ Orthopedic (bone or joint) problems \_\_\_\_\_
- \_\_\_\_\_ Anxiety/Depression \_\_\_\_\_
- \_\_\_\_\_ Surgeries/Hospitalizations (list with dates) \_\_\_\_\_
- \_\_\_\_\_ Others \_\_\_\_\_
- \_\_\_\_\_ Family History (list condition and relationship) \_\_\_\_\_

DOES THE PATIENT USE TOBACCO? \_\_\_\_\_ WHAT KIND: \_\_\_\_\_ HOW MUCH: \_\_\_\_\_

DOES THE PATIENT DRINK ALCOHOL? \_\_\_\_\_ WHAT KIND: \_\_\_\_\_ HOW MUCH: \_\_\_\_\_

By signing this form, I am stating the following

- The information I am providing is accurate and up-to-date.
- I will update Health-e-Schools with any changes as soon as possible.
- This form is valid until written revocation is received by Health-e-Schools staff or student is no longer enrolled in the school system.

If you would like to speak with our medical provider about any of your child's health, please contact Health-e-Schools at (828) 467-8815.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Dear Parent or Guardian,

We are excited to announce that Health-e-Schools is available at your child's school. You may have heard this referred to as "Telemedicine". Our school nurses have been trained to work with a provider online via a safe and secure computer screen and equipment to see students if needed during the day while at school. We can treat illnesses, provide urgent care and help students manage already known medical conditions. We then work with the parent or guardian, the school nurses and your child's primary care physician to provide the best care possible. If your student is seen at school and will need medication, it can be called in to the pharmacy you normally use. Our provider will also contact you later that day to discuss the visit and any concerns we note. You will have access to your chart and other information by visiting our online portal at [www.14072.portal.athenahealth.com](http://www.14072.portal.athenahealth.com) once the patient has been evaluated by a medical provider. Each student is encouraged to utilize this service. Your insurance will be billed just as it is when you visit your physician and if you have a copay, you will receive a bill in the mail for your copay amount. We also bill Medicaid and NC Health Choice. If your child is uninsured, we will work with you to ensure that he/she receives the same affordable care as well. Appointments may be scheduled by emailing [appts@crhi.org](mailto:appts@crhi.org), or by the school nurse. *Nurses will always call a parent or guardian prior scheduling your student to see one of our providers. **In order to do this for your child, we need you to complete the attached health questionnaire and the registration form. Please be sure and complete both sides of the form, sign, and return to your child's teacher or nurse.***

***We can diagnose and treat:***

- ***sinus congestion, common allergies, cold symptoms***
- ***asthma & spirometry***
- ***sore/strep throat***
- ***ear ache/infections***
- ***urinary symptoms***
- ***behavioral health issues such as ADHD***
- ***conjunctivitis ("pink eye")***
- ***many other common conditions and illnesses***

If your child does not have a fever and is not diagnosed with a contagious condition, he/she will be allowed to finish their day at school. Any recommended prescriptions will be sent to your pharmacy. A copy of the visit note will be faxed to your primary care provider. The provider can also send the nurse a school note if indicated.

We look forward to assisting you and your student by providing health care services at their school. Parents are encouraged to contact Health-e-Schools with medical concerns so that we can work together to provide the best care for each student. We are always open to questions or concerns and welcome your feedback. Please visit our website, email or call if you need additional information.

Sincerely, The Health-e-Schools Staff

Amanda Martin, Executive Director: [Amanda.Martin@CRHI.org](mailto:Amanda.Martin@CRHI.org)

Dr. Steve North, MD MPH: [Steve.North@CRHI.org](mailto:Steve.North@CRHI.org)

Tonya Hensley, Family Nurse Practitioner: [Tonya.Hensley@CRHI.org](mailto:Tonya.Hensley@CRHI.org)

Lacey Jones, Program Director, Mitchell & Yancey Counties: [Lacey.Jones@CRHI.org](mailto:Lacey.Jones@CRHI.org)

Christy Lewis, LPN, Program Director, McDowell County: [Christy.Lewis@CRHI.org](mailto:Christy.Lewis@CRHI.org)

Allison Bell, Program Director, Burke County: [Allison.Bell@CRHI.org](mailto:Allison.Bell@CRHI.org)

James Sharp, Mitchell & Yancey Coordinator: [James.Sharp@CRHI.org](mailto:James.Sharp@CRHI.org)

For more information, please visit [Health-e-Schools.com](http://Health-e-Schools.com) [CRHI.org](http://CRHI.org) email: [APPTS@CRHI.org](mailto:APPTS@CRHI.org)