# WATKINS HEALTH SERVICES
# THE UNIVERSITY OF KANSAS

# Youth Program / Camp Participant Health Services Information And Required Forms

Accredited by **Accreditation Association for Ambulatory Health Care, Inc.**

Watkins Memorial Health Center ● 1200 Schwegler Drive ● Lawrence, KS 66045-7559
(785) 864-9500 ● www.studenthealth.ku.edu

**WATKINS HEALTH SERVICES**
**THE UNIVERSITY OF KANSAS**

January 2015

## FOR ADMINISTRATORS OF YOUTH PROGRAMS / CAMPS

Dear Administrator:

Watkins Health Services (WHS), on the KU campus wants to be your program's health care provider. WHS provides youth program participants with the same high quality health care that KU students receive, and from the same certified professionals. These services include: Medical evaluations, allergy injections, pharmacy, laboratory, X-rays, and physical therapy. All of our physicians are board certified.

While we do prefer appointments to be scheduled, we certainly understand that issues arise which require prompt attention. Therefore, we do have a Walk-In / Triage process to provide an immediate evaluation of the individual's needs.

Enclosed you will find the following forms that must be completed by each participant's parent or guardian.

- Health Form
- Treatment Agreement

When a youth program / camp participant is brought to WHS for care, it is vital for these forms to accompany the youth to ensure we have the best possible information on his/her health history as well as emergency contact information. The enclosed "Notice of Privacy Practices" is for information purposes only. There is nothing to complete on this document and it need not be returned.

We function very much like a large clinic where patients are seen by nurses, nurse practitioners and physicians. There are charges for office visits as well as for any services ordered such as lab tests, X-rays, medications, etc. If any charges are to be billed to an insurance company, a copy of the participant's insurance card(s) **must** also be provided during the initial visit. **PLEASE NOTE: We cannot and will not bill Medicare, Medicaid, KanCare, etc. as we are not a participating provider with these or similar government programs.**

Youth program / camp participants often bring personal medications to campus, which are sometimes forgotten and left behind when they return home. Many of these medications are quite expensive, **so please be sure they are sent home with the participants**, or mailed to them if medications are found after the participants leave. Our Pharmacy (by state law) **cannot** accept for disposal or for mailing **any** prescription medications or over-the-counter medications.

For our Hours of Operation and other information, please visit our website: http://www.studenthealth.ku.edu/

If we can be of further assistance or answer any questions, please feel free to contact our Business Office at 785-864-9520.

Joe D. Gillespie, MHS, RHIA
Sr. Associate Director
Watkins Health Services

# HEALTH FORM FOR YOUTH PROGRAM PARTICIPANT

**This completed form must accompany the individual on <u>first</u> visit to Watkins Health Services.**

**Name of Program / Camp:** _____

**Name & Contact Information for Program's Administrator:** _____

_____

Youth's Name _____ Birth Date _____ Sex_____
Last First Middle

Parent Name _____ Best Phone # to call _____

Address _____
Street City, State Zip

Emergency Contact, if other than above: Name _____ Best Phone # to call_____

Relationship to Youth _____

Name of Family Physician_____ Phone #_____

1. **Does the youth have any significant illness or disability?** ❑ YES ❑ NO If yes, please explain _____

_____

2. **Please check if the youth has or has had any of the following health conditions:**
   ❑ asthma ❑ mental health ❑ dizziness/fainting ❑ diabetes ❑ epilepsy ❑ kidney problems
   ❑ tuberculosis ❑ cardiac ❑ headaches ❑ other _____

3. **Has the youth had any other significant illnesses, injuries, or surgeries?** ❑ YES ❑ NO If yes, please explain_____

_____

4. **Medications and their dosages taken by the youth**

| Name of Medication | Dosage | Frequency | Reason Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

5. **Immunization History – Please provide dates for the following OR provide a copy of an Official Immunization Record**

   Last Tetanus (Tdap) booster: _____ (should be updated no longer than every 10 years)

   DPT 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

   MMR 1st _____ 2nd _____

   Polio 1st _____ 2nd _____

   Meningococcal conjugate vaccine (MCV) _____

   Hepatitis A 1st _____2nd _____

   Hepatitis B 1st _____2nd _____ 3rd _____

   Chicken Pox (Varicella) 1st _____ 2nd _____

   TB skin test – Date of Negative Result _____ OR Positive Result _____

6. **Is the youth allergic to any medications?** ❑ YES ❑ NO If yes, please list _____
7. **Does the youth have any other allergies?** ❑ YES ❑ NO If yes, please list _____
8. **Do any allergies require an EPI Pen injection?** ❑ YES ❑ NO If yes, please list _____

***Please complete the required information on next page of this form.***

## HEALTH INSURANCE BILLING INFORMATION

***Please note*:**

(1) *If any charges are to be billed to an insurance company, a copy of the youth program participant's insurance card(s) must be provided at the time of the first visit to WHS.*

(2) *We cannot bill Medicare or any state's Medicaid program as we are not participating providers with these or similar government programs.*

(3) *The "Policy Holder*" is the adult who carries this insurance and not the youth who is covered by the policy.*

**Please provide the following information for this youth camp participant along with a copy of the Insurance Card:**

Insurance Company _____

Claim Form Address _____

Member I.D. # _____ Group # _____ ____

***POLICY HOLDER'S Printed Name:** _____**Date of Birth**_____ **Soc. Sec. No.**_____

***Full Address of Policyholder:***_____

## CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide information about how Watkins Health Services (WHS) can use or disclose patient medical information. As described in our NPP, we hereby request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent. A copy of the NPP has been provided to the Administrator of this Summer Program and the NPP is available for viewing on our website: http://studenthealth.ku.edu/about .

By signing this Consent form, you: (1) Acknowledge that a copy of the NPP has been made available to you; and (2) Consent to our use and disclosure of the patient's health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed the patient's health information in reliance upon this Consent.

I hereby authorize Watkins Health Services to disclose any information from this youth's medical record as needed to carry out treatment, payment or health care operations as explained in their Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date _____

Relationship to Patient: _____

**Our Contact Information:**

Watkins Health Services
1200 Schwegler Dr.
Lawrence, KS 66045
Fax: 785-864-9502
Email: health@ku.edu
Website: www.studenthealth.ku.edu

# - TREATMENT AGREEMENT FOR YOUTH PROGRAM PARTICIPANT -
# WATKINS HEALTH SERVICES AT THE UNIVERSITY OF KANSAS

I acknowledge that I am the parent or guardian of the youth participating in a KU program and that I am authorized to sign this document on behalf of this participant.

## CONSENT TO TREATMENT OF A MINOR

1. I hereby consent to such health care as may be deemed necessary by the providers at Watkins Health Services (WHS) including x-ray examination, lab tests, administration of medications, and any other diagnostic or therapeutic treatments.
2. I acknowledge that if urgent care is needed, it may not be possible to notify me in advance of such care but that I will subsequently be contacted.

## GENERAL CONDITIONS FOR SERVICES BY WATKINS HEALTH SERVICES

3. I understand that WHS is not responsible for loss or damage to clothing, jewelry or other valuables in the youth's possession.
4. It is my responsibility to provide a copy of any living will, medical power of attorney, or other directive that could affect care.

## INSURANCE ASSIGNMENT

5. I hereby assign all benefits payable under the terms of my insurance policy/healthcare coverage to WHS, and I authorize payment directly to WHS for any claim filed on behalf of the person for whom I am duly authorized to sign for insurance benefits.

## ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

6. **I understand that WHS does not contract with all insurance companies** and it is my responsibility to know the extent to which my insurance plan provides coverage for WHS services. And is my responsibility to verify if my plan requires a referral or pre-approval for such services at WHS.
7. **Further, I understand that WHS is not a contracting provider for and cannot bill Medicare or any state's Medicaid program.** If I have healthcare benefits under this type of government program, I am responsible for paying all WHS charges and it is my responsibility to seek reimbursement from these programs if it is my decision to do so.
8. I understand that I am financially responsible to WHS for any charges, co-pays and deductibles not covered by my insurance company/health plan. And, I understand that if I do not pay the bill within **90 days** of the date of service, the overdue account will be sent to a collection agency.
9. If I do not want my insurance company/health plan billed, it is my obligation to immediately notify the WHS Business Office. I understand that I may address any questions concerning charges, billing or payments to the WHS Business Office.
10. I understand if my Youth Program participant makes an appointment and then fails to keep the appointment without notifying WHS, a "no show" fee will be assessed.

_____
Print Name of Patient/Camp Participant

_____ _____
Signature of Parent, Guardian or Representative Relationship to Patient/Camp Participant

_____ Date: _____
Print Name of Parent, Guardian or Representative

Personal Representative's Address and Phone Number:

_____

_____

_____

*Patient Label*