New Horizons Solutions, Inc.

Dear Parent or Guardian:

New Horizons Solutions, Inc. (NHS) will be at your child's Community Center to perform health screenings that will include medical, vision, hearing, developmental/behavioral, and dental. If the examination results indicate your child is in need of closer attention in any of these areas, a referral will be made to appropriate medical personnel based on findings. NHS will NOT be treating your child. If you do not have a provider, one will be chosen for you by your Managed Care Organization.

These health screenings are being provided at the school and are done during school hours. If you are interested in your child having a health screening, please complete the following forms (including signing the consent) and return to the school as soon as possible. These services are also provided by your Primary Care Provider. If you are seeing your PCP, please continue to do so.

Please complete each enclosed form.
If you need help with these forms, please call (615) 474-2761
and we will be happy to assist you.

The screenings include the following:

A comprehensive history including developmental/behavioral screenings.

Vision and hearing screenings.

A complete head-to-toe physical exam (your child will be partially unclothed, but suitably draped during this exam – a staff member will be present).

Immunization review: Parents must give signed consent for release of immunization record (shot record) to be reviewed by New Horizons Solutions, Inc. staff. We will follow up with you if immunizations are needed.

The following lab (blood work) is collected from a finger stick and lab will be completed only: (a) at the ages shown below (b) when requested by parents/guardians (c) when medically necessary.

Urine:	Five year olds and 16 year olds and older
Hematocrit /Hemoglobin (Iron):	Five year olds and 13 year olds and older
Total Cholesterol:	Five year olds and older at risk
Lead:	Five year olds and younger at risk
Glucose (Sugar):	Children identified at risk

New Horizons Solutions, Inc.

Dear Parent/Guardian: Contact us if you would like to be present. Call (615) 474-2761

CONSENT/REGISTRATION FORM

It is very important that you complete every question. ***Required information***

*Name of School _____ *Grade_____ *Section_____ *Teacher_____

*CHILD'S NAME (Please Print)		*CHILD'S SOCIAL SECURITY NUMBER :	
ADDRESS:			
CITY:		STATE:	ZIP CODE:
SEX: __ Male __Female	AGE:	*DATE OF BIRTH:	
NAME OF CHILD'S DOCTOR OR CLINIC:			
NAME OF INSURANCE CARRIER: *(Please circle one)*		Tenn-Care Select, BlueCare, Cigna, AmeriChoice AmeriGroup, John Deere, United Health Community CCareInsurance	
MEMBER ID:		MEDICAID ID:	

PARENT OR GUARDIAN'S INFORMATION

*RESPONSIBLE PARTY'S NAME :		RELATIONSHIP TO CHILD:
*HOME PHONE NUMBER: ( )	WORK PHONE NUMBER: ( )	*CELL NUMBER: ( )
PRIMARY LANGUAGE SPOKEN AT HOME:		
*FRIEND OR RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY: Name: _____ Relationship: _____ PHONE: ( )		

An UNCLOTHED EXAM is the same as in your doctor's office and includes the following procedures:
1. Listening to the heart and lungs; 2. Feeling and listening to the stomach; 3. Checking the back for scoliosis (curve of the spine); 4.Checking the femoral pulse (a heart beat located on the lower stomach and upper leg); 5. Examining the skin for problems such as rashes or infections; 6. Assessing stages of development through observation.

A Pediatric or Family Practice Nurse will conduct the unclothed exam behind a privacy screen. During the unclothed exam, clothes will be lifted. The Provider will ask your child for their permission to complete each part of the exam.

You are encouraged to be present during the entire exam.

PARENT or GUARDIAN CONSENT AND ACKNOWLEGMENT:

My child has permission to receive the annual physical exam conducted by New Horizons Solutions, Inc.,. I have been notified of NHS's privacy practices. I give permission for my child's screening results to be released to my Managed Care Organization (MCO), Health Department, the school system for treatment purposes, and my child's physician/primary care provider. I give my permission to release my child's immunization record (shot record) for review by New Horizons Solutions, Inc.

Do you want to be present during the exam? [ ] Yes [ ] No

***Date:_____** ***Parent/Guardian Signature_____**

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