Berger Tiger Care Clinic





Partnering for Health & Wellness

Circleville City Schools has teamed up with Berger Health System to provide convenient and affordable healthcare through the new Berger Tiger Care Clinic for students and school employees.

Personalized Healthcare on Your Schedule

Illness doesn't take appointments and neither do we - just come in when you need us.

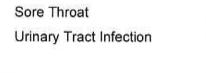
For students, parents will need to complete the 2017-2018 Parental Consent For Treatment form and a Student Medical Information form prior to being seen in the Clinic. Complete it once during the school year and we will keep it on file - just let us know if you have any updates or medical condition changes we should be aware of.

Berger's Tiger Care Clinic encourages the presence of a parent/guardian at all clinic visits. If that is not possible, the provider will call the parent/quardian on file to communicate about the visit; if a parent/guardian is not available, care will be provided in accordance with the completed consent.

We're here to help you feel better when you need us for conditions such as:

- Allergy Symptoms
- Bronchitis
- Common Cold Symptoms
- Conjunctivitis (pink eye)
- Ear Pain
- Flu Symptoms
- Sinus Symptoms

- Skin Infections
- Skin Rashes
- Sports Physicals
- Sprains/Strains



Clinic visit subject to provider office visit insurance copay, which will be billed after the visit by Berger Health Partners.



Clinic Hours:

| Monday | 8:00 am | 11:00 am |
|-----------|---------|----------|
| Wednesday | 8:00 am | 11:00 am |
| Friday | 8:00 am | 11:00 am |

Clinic hours will be evaluated on a quarterly basis

Clinic Location: Circleville Elementary School

100 Tiger Drive

Circleville Ohio 43113

Questions?

Give us a call at 740-420-8354



Berger's Tiger Care Clinic 2017-2018 Parental Consent For Treatment



| Student Name (please print): | | se print): | Date of Birth: | | | | |
|---|--|---|--|--|--|--|--|
| | Consent for Medical Care / Treatment | staff to provide care for the above named student ("Studen | sion to Berger's Tiger Care Clinic certified nurse practitioner, physician, and the above named student ("Student") during the 2017-18 school year. It can be withdrawn at any time upon written notice to Berger's Tiger Care automatically expire at the end of the 2017-18 school year. | | | | |
| | | I consent for my Student to be treated for minor acute illne basic laboratory services and tests, as determined by the Be practitioner or physician to be in the best interest of my Stu include, but are not limited to: Allergy symptoms, Bronchitis Symptoms, Skin Rashes, Sprains/Strains, Sore Throat, and U | erger Tiger Care Clinic certified nurse dent. Such minor illnesses or injuries s, Common Cold Symptoms, Pink Eye, Flu | | | | |
| | | I understand it is my responsibility to follow up on the medi with my Student's personal physician or other healthcare pr Clinic does not assume responsibility for management of ch not able to be present with my student, he or she will receiv instructions and it is my responsibility to review these instru | ovider. I understand that Berger Tiger Care ronic conditions. I understand that if I am re a written summary and follow-up | | | | |
| | | I understand it is my responsibility to accurately communica about my student's chronic health conditions, medications, that he/she can receive the most appropriate care possible. | | | | | |
| | | I acknowledge that treatment at the Berger Tiger Care Clinic is intended to address specific episodic illnesses or injury and is not intended to be a substitute for comprehensive care provided by a primary care or specialized physician or provider. | | | | | |
| | | I understand that Berger's Tiger Care Clinic encourages the presence of a parent/guardian at all clinic visits. If that is not possible, the provider will call the parent/guardian on file to communicate about the visit; if a parent/guardian is not available, I understand that care will still be provided in accordance with this Consent. I understand that a visit summary may be shared with my child's Primary Care Provider to ensure continuity of care. | | | | | |
| | | I understand that any necessary prescriptions will be transmithe medical information form. In order for the provider to nichild's healthcare, I grant permission to the provider to obtain same pharmacy when necessary. | nake well informed decisions about my | | | | |
| | I voluntarily give permission for Berger's Tiger Care Clinic to obtain a copy of my Stud | | | | | | |
| immunization record from the student's school, primary care provider and/or local hea | | | | | | | |
| Ø | Financial Responsibility | I understand that Berger Health Partners will bill my Student's health insurance for services provided in the Berger Tiger Care Clinic. I understand that I am responsible for any co-pays or deductibles or any amount not covered by health insurance. However, no child will be denied care due to the inability to pay for services. Neither Berger Health System nor Berger Health Partners are financially responsible for any visits or testing, such as specialist evaluations, imaging, lab tests, medications, or durable medical equipment, that are provided outside of the Berger Tiger Care Clinic. | | | | | |
| \checkmark | Notice of | ice of I have received/been offered a copy of Berger Health System's Notice of Privacy Practices. | | | | | |
| | Privacy Practices | I understand that if I have any questions regarding the information in Berger Health System's Notice of Privacy Practices, I may contact the Privacy Officer at (740) 420-8399. | | | | | |
| Pare | nt/Guardian Nam | | Phone Number: | | | | |
| Pare | nt/Guardian Signa | iture: | Date: | | | | |



Berger's Tiger Care Clinic
Mailing Address: 600 N Pickaway Street | Circleville, OH 43113 | Phone: 740-420-8354



Student Health Information

| Student Name: | | | | | Date of Birth: | | | |
|--|----------------------|--|---|---------------|----------------------|----------------------|--|--|
| Prefer To Be Called: | | | Social Security Number: | | | | Sex: ☐ Male ☐ Female | |
| Home Address: | | | City: | | | | Zip: | |
| Home Phone Number: Cell Phone Numb | | | nber: Ma | | | | May we leave a message if necessary? ☐YES ☐NO | |
| | | | If your child should need a prescription, where should I send it to be filled (pharmacy): | | | | | |
| Emergency Contact Information | (List in order you v | would lik | e us | to call if th | nere w | ere an emer | gency situation) | |
| Name: Phone Number: | | A STATE OF THE PARTY OF THE PAR | | | | Relation to Student: | | |
| Name: Phone Num | | Number: | | | Relation to Student: | | | |
| Name: Phone Number | | | | | | Relation to Student: | | |
| Medical Information | | | | W. | | | | |
| 2. Is your child taking any medicines/drugs (include non-prescriptes) If yes, please list: | | | symptoms: Cavities or tooth pain/injuries Missing or damaged organs (eye, kidney, testicle) | | | | | |
| 4. Has your child had any major injur | ies or been in the h | | | | | | | |
| If yes, what surgeries/injuries or | why were they in t | the hospi | ital? | | | | | |
| Parent/Guardian Signature: | | | - 11.5 | | Date: | | | |