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/guardian 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
- Sore Throat
- Urinary Tract Infection

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): _____ **Date of Birth:** _____

☐	**Consent for Medical Care / Treatment**	I voluntarily give permission to Berger's Tiger Care Clinic certified nurse practitioner, physician, and staff to provide care for the above named student ("Student") during the 2017-18 school year. I understand that consent can be withdrawn at any time upon written notice to Berger's Tiger Care Clinic. This consent will automatically expire at the end of the 2017-18 school year. I consent for my Student to be treated for minor acute illnesses or injuries, including the provision of basic laboratory services and tests, as determined by the Berger Tiger Care Clinic certified nurse practitioner or physician to be in the best interest of my Student. Such minor illnesses or injuries include, but are not limited to: Allergy symptoms, Bronchitis, Common Cold Symptoms, Pink Eye, Flu Symptoms, Skin Rashes, Sprains/Strains, Sore Throat, and Urinary Tract Infections. I understand it is my responsibility to follow up on the medical information received during any visit with my Student's personal physician or other healthcare provider. I understand that Berger Tiger Care Clinic does not assume responsibility for management of chronic conditions. I understand that if I am not able to be present with my student, he or she will receive a written summary and follow-up instructions and it is my responsibility to review these instructions. I understand it is my responsibility to accurately communicate and update the Berger Tiger Care Clinic about my student's chronic health conditions, medications, allergies, treatment preferences, etc. so 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 transmitted to the pharmacy of choice listed on the medical information form. In order for the provider to make well informed decisions about my child's healthcare, I grant permission to the provider to obtain my child's medication history from the same pharmacy when necessary. I voluntarily give permission for Berger's Tiger Care Clinic to obtain a copy of my Student's immunization record from the student's school, primary care provider and/or local health department.
☑	**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.
☑	**Notice of Privacy Practices**	I have received/been offered a copy of Berger Health System's Notice of 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.

Parent/Guardian Name (Please Print):	**Phone Number:**
Parent/Guardian Signature:	**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 Number:	May we leave a message if necessary? ☐YES ☐NO
Child's Physician Name and Number:	If your child should need a prescription, where should I send it to be filled (pharmacy):	

Emergency Contact Information (List in order you would like us to call if there were an emergency situation)

Name:	Phone Number:	Relation to Student:
Name:	Phone Number:	Relation to Student:
Name:	Phone Number:	Relation to Student:

Medical Information

1. Has your child ever had reaction to any of the following:
   - ❑ No known allergies ❑ Latex (rubber gloves) ❑ Eggs ❑ Peanuts ❑ Bee stings ❑ Shellfish
   - ❑ Medicines/Drugs (please describe) _____

2. Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements) daily?
   ❑ YES ❑ NO
   If yes, please list:_____

3. Has your child had any of the following health problems or symptoms:
   - ❑ Allergies (seasonal, hay fever, etc)
   - ❑ Asthma
   - ❑ Autoimmune disorder (lupus/juvenile arthritis /celiac disease)
   - ❑ Blood disorders (sickle cell/clotting problems)
   - ❑ Cancer: Type_____
   - ❑ Diabetes: (circle one) pre-diabetes, type 1, or type 2
   - ❑ Heart problems (including murmur or high blood pressure)
   - ❑ High cholesterol
   - ❑ Broken bones: where? _____
   - ❑ Stomach problems:

   Type_____
   - ❑ Cavities or tooth pain/injuries
   - ❑ Missing or damaged organs (eye, kidney, testicle)
   - ❑ Many headaches/migraines
   - ❑ Head injury, concussion or seizures
   - ❑ Problems since birth (birth defect, down syndrome, autism, genetic disorder) Type: _____
   - ❑ Developmental delay
   - ❑ Mental health condition (ADHD, anxiety, depression, etc.)
   - ❑ Other_____

4. Has your child had any major injuries or been in the hospital overnight? ❑ YES ❑ NO
   If yes, what surgeries/injuries or why were they in the hospital? _____

Parent/Guardian Signature:	Date: