

Dear Parents/Guardians:

Did you know that your son or daughter can get **Health Care** at school? Madison Middle School has a School-based Health Center (SBHC) that is located in the building and its services are available to all students. The SBHC is operated by Neighborcare Health, a community health center serving more than 70,000 people in Seattle and Vashon Island each year.

The SBHC offers a child friendly setting and all the services of a family doctor. The SBHC provides appointments before, during, and after school and offers the following services:

- Evaluation and treatment of common health problems
- Immunizations, lab tests, and medication management
- · Sports physicals
- Reproductive health care
- Mental, social, and emotional health care

- Oral health care, including screening, exams, and treatment
- Preventive health care, including tobacco, alcohol, and other drug use prevention education
- Health insurance eligibility and enrollment assistance
- Referrals to other health care providers as needed

To use this service, please complete and sign the following forms in this packet:		
	Health History Form (pg. 2)	
	Registration Form (pg. 3)	
	Consent Form (pg. 4)	
	Dental Screening Form (pg. 5) (Optional)	

Forms can be returned with the school packet or mailed to the school separately. They can also be dropped off in person at the SBHC or the school's main office.

Release of Education Records Form (pg. 6) (Optional)

A completed Release of Education Records form allows your child's school records to be shared with Neighborcare Health. Access to school records enables Neighborcare Health to work with teachers and staff to improve student learning, attendance, grades, and behavior.

Neighborcare Health is committed to serving all patients regardless of ability to pay. The Madison Middle School SBHC receives support from the Families and Education Levy, but this funding does not fully cover the program's operating costs; therefore the SBHC bills insurance when appropriate. Please complete the insurance section of the registration form to ensure that we have your most current insurance information on file.

If you do not have health insurance, the SBHC can help you enroll in an insurance plan. Please check the "No Insurance" box on the registration form and a SBHC staff member will follow-up with you. You can also call the SBHC directly to request health insurance enrollment assistance.

Madison Middle School is fortunate to have the SBHC and I hope you will take advantage of this resource for your child. If you would like more information or need assistance please call the Madison Middle School SBHC at 206-933-7842

Sincerely, R. Gary Principal



Health History Form

In order to provide the best care for your child, please fill this Health History Form as completely as possible. Thank you.

Student's N	lame:			Date (of Birth://		
(First)		(La	(Last)		, Jule 015,,,		
(Pri	inted Name of Person Completing Form)	(Relationsh	hip to Student (if not self	(Date Form Complet	ted)		
	ABOUT YOUR CHILD: Would you like your child to recei	vo a check-up wit	th our provider?				
			•	.d.,g			
□Yes □No □Yes □No		Doctor or Clinic?	-		#:		
□Yes □No					// •		
□Yes □No □Yes □No	Has your child had a dental check-up in the past year?						
	Medication	Dosage	Reason				
□Yes □No		n allergies?					
□Yes □No	,		.)				
-	i <mark>ld had any of the following (Check a</mark> oblems/ear infections	all that apply): □Vision pro	shlome	□Diabetes			
• .		□ vision pro □Asthma	репь	□Diabetes □Anemia			
	ght, overweight, or growth issues cay/teeth problems	⊔Astrima □Heart pro	blams	⊔Anemia □High blood pressi	ura		
Bone or jo		□Tuberculo		□ Fainting or passir			
-	erns about Well-Being	LIUKIGO	212.01 10	□I allithig of passi	ig out		
	worry or stress	□Rehavior (er anger næhlems	□Alcohol or drug n	micuca		
	Deficit Disorder		□Behaviororangerproblems □Conæms about my child's safety		or anxiety		
Recent Scho	ool or Learning Issues						
□Attendanα	e problems	□Worse or f	failing grades	□Delays in leaming	g or de ve lopmen t		
	with students or adults		□Suspension		□Performing below grade level		
Other healt	th conditions or concerns:						
Check all ite	ems you feel are true for your child:						
	My child engages in a healthy lifesty My child has at least one adult in the My child has at least one friend or a	eir life who cares a group of friends.	about them.	, and keeping safe			
QUESTIONS	ABOUT YOUR FAMILY:						
-	yourhome?						
□Yes □No □Yes □No	Have there been any major changes o Does anyone living at home smoke cig Are you ever concerned there will not Is there a gun in your home?: Is it lo	arettes, cigars, or t be enough food fo	e-cigarettes? or your family?	escribe:			
	ALTH HISTORY: (check all that apply			Mother's side of family	Father's side of fami		
Asthma							
Diabetes							
	lentify type ack or stroke before age 55						
High blood							
High chole							
	unexplained death						
Blood clot							
	rdrug misuse						
	n and/or anxiety						
Mental illn							
	trauma or abuse						
	ess or Conditions explain:						

When your child comes in for care, we will complete a risk assessment and review family health history

Please help us serve you better by providing the following <u>confidential</u> information and updating it every year so we have the most current information on record. This consent will remain active from year to year. To withdraw consent for services, please submit your request in writing. Student's Name: Last (Sr. Jr.) Middle: Other Names Used: (If applicable) Nickname: Student's Date of Birth: | Student's Sex listed on birth certificate (Check one): Gender identified as:__ Sexual orientation identified as:___ □ MALE □ FEMALE Student's Address: (Street or Post Office Box): Parent, Guardian, or Responsible Party: Relationship: □Parent □Grandparent □Sibling □Other Parent/Guardian Name:___ Parent/Guardian Date of Birth: ____/___/ City: State: Zip: Parent/Guardian Phone:_____ __ □Cell □Home Phone (Student):___ Parent/Guardian Address: ☐ Same as Student E-mail (Student):__ Street:____ In Case of Emergency Contact: State: Zip: Same as Parent / Guardian Information E-mail (Parent/Guardian):__ Name: _Date of Birth: __ Relationship: _____Telephone: ____ Best way to contact me: □Phone □Email □Mail *We may contact you via email. Address Zin State Language (Primary language spoken in student's home): Student Status □Amharic □Hmong □ Samoan Student ID:_____ Grade:____ □Arabic □Korean □Somali □Cambodian/Khmer □Laotian □Spanish School:___ □Mandarin □ Cantonese □Tagalog □ English □Mien □Thai □Farse \square Oromo □Tigrinya □French \square Russian □Vietnamese □Other: Please specify preferred language:___ Are you on the Free or Reduced Price Meals Program? □YES □NO ADDITIONAL QUESTIONS: **Disabled/Handicapped:** Does the patient have an ongoing condition preventing daily activities? Immigrant/Refugee: Is the patient an immigrant or refugee or new arrival to this Country? □Yes □No Total Number in household: Number of family members reported on Federal Income Tax Return:____ Household Status: Patient lives with: □Single Parent (Male) □Single Parent (Female) □Both Parents □Other Housing Status: Not Homeless Public Housing Doubling Up Shelter Street Transitional Other Unknown/Unreported Farm Worker Status: Migrant Seasonal Nota Farm Worker Interpreter Required: Is an Interpreter needed for this Patient? □Yes □No If yes, preferred language:___ **Veteran Status:** □Yes □No Income: What is your gross annual household income? \$_ Student's Race: Student's Ethnicity □ American Indian/Alaska Native □ Other Pacific Islander ☐ Hispanic or Latino □Asian □White □ Not Hispanic or Latino Black/African American ☐ More than one race □ Native Hawaiian ☐ Decline to specify Insurance Information ☐ Yes, I have health insurance. ☐ No, I do not have health insurance; please contact me with additional information on health insurance coverage options. Primary Insurance Name:____ Subscriber Name: Relationship: Identification/Policy # Plan # (if application) ____ Subscriber Gender:___ Subscriber Date of Birth: / / ___ Plan # (if applicable):___ _____ Group # (if applicable):_ __/___ Insura nce Phone #: Group Name (if applicable):_ Effective Date:___ PRIVACY PRACTICE NOTICE, RELEASE AND CONSENT SIGNATURE CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to this clinic is currently correct and understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical, Mental Health, and Dental staff of the above named clinic to employ such established treatments and therapies deemed professionally and medically necessary or a dvisable in the diagnosis and treatment of my child's health problems. I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by licensed Mental Health Therapist or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical/Dental Director. The assignment and release authorizes. Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care provider who have rendered services to me. I agree to pay all charges that are not paid in full by assigned insurance. NOTICE OF PRIVACY PRACTICES: I have received Neighborcare Health's Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information. SIGNATURE RELATIONSHIP TO STUDENT DATE

NEIGHBORCARE HEALTH REGISTRATION FORM - School-based Health Centers

Neighborcare Health School-Based Health Centers Consent for Health Services

Neighborcare Health's School-based Health Centers are located in Seattle Public Schools and Vashon Public Schools. Neighborcare Health must have signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access such treatment without parent/guardian consent. If the student is enrolled in school but is not enrolled in the School-based Health Center (SBHC), he/she can continue to receive school nurse services.

I hereby request and auth	norize that:				
Print Student's Name:				//	
	First Name	Middle Initial	Last Name	Date of Birth	
include, but are not limited evaluation and treatment services. SBHC staff end authorization is given for emergency transportation necessary by the Neighbor consent, unless she/he is dental and mental health	d to: mental health co of acute illness and in ourage family involver my child to receive se to other physicians, lorcare Health SBHC so unable to consent. No care and Neighborcar	I deemed necessary by the bunseling, routine medical expluries, immunizations, blood ment in the care they providervices in my absence. Considerath care professionals, health care professionals, health. This authorization does leighborcare Health is commediated the community the community the sunselies of the community the community the sunselies of the community the sunselies of the community that the community the community that the community the community the community the community that the community that the community the community the community that the community that the community the community that the commu	came, naturopathy, spo d studies, photographs, e to students. Howeve ent is also given for re ospitals, clinics, or hea not allow services to l itted to creating a hea erm relationships betw	orts physicals, well-ch, X-rays, dental and fr, if I am unable to be ferral of care and, if not the care agencies as one rendered without the care home that inches and provess.	hild or teen care, luoride treatment present, eeded, deemed he student's cludes medical, viders.
exceptions exist; for exar 1. Permission is given by 2. The patient indicates ri 3. The patient has a life-t 4. There is reason to sus	nple: the patient or parent/g sk of imminent harm t hreatening health prol pect abuse or neglect.	olem and is under the age o	elease of information f	•	tial. A few
best care for the above no Neighborcare Health staff	h therapist, nurse pra amed student. To faci f at the SBHC. Conser	n with the health care provinctitioner or physicians assis ilitate coordination of care, that is granted for the school escribed by the medical prov	tant and the school nui ne student's SBHC me nurse to administer ove	rse, for the purpose o dical record will be ac	f providing the cessible to
services can be received	at any Neighborcare	pendently at any of Neighbor Health medical and dental cent, call the Neighborcare P	linic. To see a list of cl	inic locations, please	
	IC or for the length of	Neighborcare Health during time services are provided he SBHC.			
Student Signature:				Date://	!
Parent/Guardian Signa	ature:			Date://	·
Name of Legally Resp	onsible Guardian (F	Print):	R	elationship:	

is

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages each student to involve his/her parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlaw.help.org and search "Minor Consent".



Dear Parent or Guardian:

We are offering dental screenings in your child's school to inform you about your child's dental health. The screenings have **no out of pocket cost to you**.

If you agree to have us screen your child:

- 1) Your child will receive **2** dental screenings during the school year. The first in **fall** and the second in **spring**.
- 2) We will be happy to give you information to make a dental appointment, or make an appointment for you, if you need a dental provider.
- 3) We will send you a copy of your child's results. This information may be shared with your child's school.
- 4) We may leave a message on your phone if we need to contact you about your child's dental needs.

School: _____ Classroom #: ___ (For Administrative Use) MRN:

What is a dental screening?

A Neighborcare dental provider will look at vour child's teeth and make a visual evaluation.

They will apply a **fluoride varnish** which is a protective coating that is painted on teeth to help prevent new cavities and to help stop cavities that have already started.

A dental screening does NOT take the place of a complete dental exam by your child's dentist.

Parents of Guardians, please in C	out the intori	nation below and sig	in the bottom of the form.
Name of child:First			
	MI	Last	Date of Birth (mm/dd/yy
Gender of child: ☐ M ☐ F			
Name of parent/guardian:First	MI	Last	Date of Diate (manufold) as
ГІІБІ	IAIT	Last	Date of Birth (mm/dd/yy
Address:		City:	Zip:
Phone #:			
Do you prefer to be contacted in a langua	age other than E	inglish? □No □Yes <i>If y</i>	yes, what language?
How would you like to receive your child's □ Please give them to my child at school			the address listed above.
When did your child last see a dentist? ☐ Less than 6 months ago ☐ Less than 1 year ago ☐ More to	han 2 years ago than 2 years ag	o □ Never o	
Does your child have a regular dentist?	□No □Yes	If yes, where?	
Would you like help finding a dentist for y	our child? □	Yes □No	
This program is without cost to you, but your lesection of this form to ensure we have the most screening. If any costs are not covered by insustudent or family participating in the program.	st current informa urance, they will t	ation. Public insurance plans be covered by grants. No out	generally cover the entire fee of the of pocket expense will be billed to any
Please list your Apple Health or other Der	ntal Insurance ir	nformation below:	
Dental Insurance Name:			
Subscriber Name:			
Relationship: Subscriber G	ender:Sı	ubscriber DOB://_	_
By signing this form you agree to	2 dental scr	eenings and fluoride	varnishes.
Signature of Parent or Guardian			Date



Community Based Organization Parent/Guardian Consent Form 2018-2019 Approval

Public Health – Seattle & King County School-Based Partnerships Program 401 5th Ave #1000 Seattle, WA 98104 206.263.8350 Neighborcare Health 1200 12th Ave S, STE 901 Seattle, WA 98144-2712 206-461-6935

Consent to Release of Education Records Under the Family Education Rights and Privacy Act (FERPA)

I consent to the release of my child's education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

- 1. Student name, DOB and contact information
- 2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
- 3. Attendance History
- 4. Discipline History
- 5. Coursework and grades History
- 6. Test Scores History
- 7. Enrollment History
- 8. Assignment Grades
- 9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child's academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child's school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health - Seattle & King County, Neighborcare Health staff will work with my child and/or his/her school in an effort to improve my child's success at school. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District's School & Community Partnership Department, MS: 33-160 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2019. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

Parent/Guardian Signature (if youth is 17 or younger):			
Parent/Guardian Printed Name:			
Student's Signature (if youth is 18 or older):			
Today's Date:			
PRINT Student's Name (First and Last name)	Student Date of Birth		
**Student School District ID # **Student ID # can be found on student ASB card, report c	Student's School eard, official school mailing, or by contacting your student's school		



NOTICE OF PRIVACY PRACTICES

THIS NOTICE EXPLAINS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND GIVEN OUT. IT ALSO EXPLAINS HOW YOU COULD GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neighborcare Health respects your privacy. We understand that your personal health information is very sensitive. We will not give out your information to others unless you tell us to, or unless the law allows or requires us to do so.

We are required by law to keep your Protected Health Information (PHI) private, to give you this Notice, and follow the terms of this Notice. We also have the right to change our practices. If we make changes to this Notice, you will receive the updated Notice upon your next visit. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website at neighborcare.org.

PHI is any information that includes your personal information, as well as health and billing information. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USING AND RELEASING PROTECTED HEALTH INFORMATION

- A. Without Your Written Permission. We have the right to use and share your health information for the following reasons:
 - 1. Treatment: Information obtained by a nurse, physician, or other members of our health care team, recorded in your medical record, may be used to help decide your future care. We may also share information to others providing you care. This will help them stay informed about your care.
 - 2. Payment: We request payment from your health insurance plan. Health plans need information from us about your medical care. Information shared with health plans may include your diagnoses, procedures performed, or future recommended care.
 - 3. Health Care Operations: We may use and share PHI for our health care operations, such as quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff.
 - **4. Required or Permitted by Law:** We may share PHI when we are required or permitted to do so by law. For example, we may release PHI to proper authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence. We may also share PHI necessary to stop a serious threat to the health or safety of you or others. Other releases could include: public health activities; requests from state or federal agencies; law enforcement; court order or other lawful process; approved research; workers' compensation claims; military or national security agencies, coroners, medical examiners, and correctional institutions.

B. Without Your Permission, And You May Object.

- I. Fundraising: We may use PHI to contact you in an effort to raise money for our operations. We may also release PHI to a foundation that is related to us so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications
- 2. Family and Other Persons Involved in Your Care. Unless you object, we may share your PHI with a family member, relative, close friend, or any other person you identify is involved in your medical care. We may share information to notify the person of your location, general condition or payment related to your care.
- 3. **Disaster Relief Efforts.** We may share your protected PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for coordinating notification of family members of your location, general condition, or death.

C. Needs Your Written Permission.

- 1. Psychotherapy Notes. We must get your permission to use or release psychotherapy notes, unless the psychotherapy notes are:
 - (I) By the creator of the psychotherapy notes for treatment purposes,
 - (2) For our own training programs in which mental health students, trainees or practitioners learn to improve their counseling skills,
 - (3) To defend ourselves in a legal proceeding initiated by you,
 - (4) To a health oversight agency for oversight of the creator of the psychotherapy notes,
 - (5) To a coroner or medical examiner; or
 - (6) To prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.
- 2. Minors. We will follow Washington State law when using or sharing PHI of minors. Minors who receive health care services related to HIV/AIDS; STDs, mental health treatment, alcohol/drug testing, and treatment or reproductive health may request that another person receive that information on their behalf. If the minor does not give permission in writing to anyone, we will only give information to the minor.
- 3. Marketing Communications: Sale of PHI. We must have your written permission before using or sharing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Releases. Any requests for information besides those described in this Notice will need your written permission. For example, you will need to sign a permission form before we can send PHI to your life insurance company or to your attorney. You may revoke your permission at any time by providing us with a written request.

II. YOUR INDIVIDUAL RIGHTS

- A. Right to Inspect and Copy. You may request to see your medical records billing records in order to inspect and/or request copies of the records. All requests to view records must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the cost of copying and sending records you request.
- **B.** Right to Alternative Communications. You may request in writing to receive PHI by alternative means of communication or at alternative locations.
- C. Right to Request Restrictions. You have the right to limit PHI we use or share for treatment, payment, or health care operations. You must request limitations in writing addressed to Neighborcare Health's Privacy Officer. We are not required to agree to limitations you request, unless your request is to limit releasing PHI to a health plan for payment or health care operations and that PHI directly relates to a health care item or service that you or another person or entity on your behalf paid in full.
- **D. Right to Accounting of Releases.** You may request in writing an accounting of releases of PHI made by us in the last six years, subject to certain restrictions and limitations.
- **E. Right to Request Amendment:** You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
- F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to Neighborcare Health's Privacy Officer at 206-548-3045 at any time.
- **G. Right to Receive Notification of a Breach.** We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.
- **H. Questions and Complaints.** If you have questions about your privacy rights, or are concerned that we have violated your privacy rights, you may contact Neighborcare Health's Privacy Officer at 206-548-3045. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE

A. Effective Date. This Notice is effective on September 23, 2013.