VASHON ISLAND SCHOOL DISTRICT

2018-2019 School Year

Dear Parents/Guardians:

Did you know that your son or daughter can get **Health Care** at school? Vashon Island High School has a School-based Health Center (SBHC) that is located in the building and its services are available to all Chautauqua Elementary School 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 (for adolescent students)
- Mental, social, and emotional health care (*offered onsite at Vashon Island High and Chautauqua Elementary schools*)
- Oral health care, including screening, exams, and treatment (*offered onsite at Vashon Island High, McMurray Middle, and Chautauqua Elementary schools*)
- 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 Consent 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.

Neighborcare Health is committed to serving all patients regardless of ability to pay. The Vashon Island High School SBHC receives support from the Best Starts for Kids 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.

Chautauqua Elementary School is fortunate to have access to 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 Vashon Island High School SBHC at 206-548-7550.

Sincerely,
Rebecca Goertzel
Principal

If you would like a translated copy of this information, please visit www.neighborcare.org

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School-based Health Centers

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 Name:_____ Date of Birth: ____/____/____
(First) (Last)

_____ _____ _____
(Printed Name of Person Completing Form) (Relationship to Student (if not self) (Date Form Completed)

QUESTIONS ABOUT YOUR CHILD:

☐**Yes** ☐**No** **Would you like your child to receive a check-up with our provider?**

☐**Yes** ☐**No** **Would you like your child to receive a dental screening with our provider?**

☐Yes ☐No Does your child have a Primary Care Doctor or Clinic?
Provider Name:_____ Clinic Name:_____ Phone #:_____

☐Yes ☐No Has your child had a physical or full check-up in the past year?

☐Yes ☐No Has your child had a dental check-up in the past year?

☐Yes ☐No Does your child take any medications? (include vitamins and over-the-counter medications)

Medication	**Dosage**	**Reason**
_____	_____	_____
_____	_____	_____

☐Yes ☐No Does your child have any medication allergies? _____ _____ _____

☐Yes ☐No Does your child have other allergies? (foods, dust, etc.) _____ _____ _____

Has your child had any of the following (Check all that apply):

☐Hearing problems/ear infections	☐Vision problems	☐Diabetes
☐Underweight, overweight, or growth issues	☐Asthma	☐Anemia
☐Dental decay/teeth problems	☐Heart problems	☐High blood pressure
☐Bone or joint injury	☐Tuberculosis or TB	☐Fainting or passing out

Other Concerns about Well-Being

☐Too much worry or stress	☐Behavior or anger problems	☐Alcohol or drug misuse
☐Attention Deficit Disorder	☐Concerns about my child's safety	☐Depression and/or anxiety

Recent School or Learning Issues

☐Attendance problems	☐Worse or failing grades	☐Delays in learning or development
☐Problems with students or adults	☐Suspension	☐Performing below grade level

Other health conditions or concerns:_____

Check all items you feel are true for your child:

☐Yes ☐No My child engages in a healthy lifestyle; eating healthy foods, being active, and keeping safe

☐Yes ☐No My child has at least one adult in their life who cares about them.

☐Yes ☐No My child has at least one friend or a group of friends.

☐Yes ☐No My child has a sense of hopefulness and self-confidence.

QUESTIONS ABOUT YOUR FAMILY:

Who lives in your home?_____

☐Yes ☐No Have there been any major changes or challenges in the past year? If yes, describe:_____

☐Yes ☐No Does anyone living at home smoke cigarettes, cigars, or e-cigarettes?

☐Yes ☐No Are you ever concerned there will not be enough food for your family?

☐Yes ☐No Is there a gun in your home? : Is it locked? ☐Yes ☐No

FAMILY HEALTH HISTORY: (check all that apply)	**Father**	**Mother**	**Mother's side of family**	**Father's side of family**
Asthma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer; identify type	☐	☐	☐	☐
Heart attack or stroke before age 55	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Sudden or unexplained death	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐
Alcohol or drug misuse	☐	☐	☐	☐
Depression and/or anxiety	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
History of trauma or abuse	☐	☐	☐	☐
Other Illness or Conditions explain:_____				

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

NEIGHBORCARE HEALTH REGISTRATION FORM - School-based Health Centers

Please help us serve you better by providing the following confidential 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.) First: Middle: | Other Names Used: *(If applicable)* | Nickname:

Student's Date of Birth: _____/_____/_____

Student's Sex listed on birth certificate (Check one): ☐MALE ☐FEMALE

Gender identified as:_____

Sexual orientation identified as:_____

Student's Address: (Street or Post Office Box):

City: State: Zip:

Phone ***(Student)***:_____

E-mail ***(Student)***:_____

In Case of Emergency Contact:

☐ Same as Parent/Guardian Information

Name: _____Date of Birth: _____

Relationship: _____Telephone: _____

_____

Address City State Zip

Parent, Guardian, or Responsible Party:

Relationship: ☐Parent ☐Grandparent ☐Sibling ☐Other

Parent/Guardian Name:_____

Parent/Guardian Date of Birth: _____/_____/_____

Parent/Guardian Phone:_____ ☐Cell ☐Home

Parent/Guardian Address: ☐Same as Student

Street:_____

City:_____ State:_____ Zip:_____

E-mail ***(Parent/Guardian)***:_____

Best way to contact me: ☐Phone ☐Email ☐Mail

**We may contact you via email.*

Language (Primary language spoken in student's home):

☐Amharic	☐Hmong	☐Samoan
☐Arabic	☐Korean	☐Somali
☐Cambodian/Khmer	☐Laotian	☐Spanish
☐Cantonese	☐Mandarin	☐Tagalog
☐English	☐Mien	☐Thai
☐Farse	☐Oromo	☐Tigrinya
☐French	☐Russian	☐Vietnamese

☐Other: Please specify preferred language:_____

Student Status

Student ID:_____ Grade:_____

School:_____

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? ☐Yes ☐No
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 ☐Not a 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:

☐American Indian/Alaska Native	☐Other Pacific Islander
☐Asian	☐White
☐Black/African American	☐More than one race
☐Native Hawaiian	☐Decline to specify

Student's Ethnicity

☐Hispanic or Latino
☐Not Hispanic or Latino

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:_____ Subscriber Gender:_____ Subscriber Date of Birth:_____/_____/_____

Identification/Policy #_____ Plan # (if applicable):_____ Group # (if applicable):_____

Group Name (if applicable):_____ Effective Date:_____/_____/_____ Insurance Phone #:_____

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 advisable 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 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 authorize that:

Print Student's Name: _____ ___/___/____
First Name Middle Initial Last Name Date of Birth

receive health care services available from and deemed necessary by the Neighborcare Health SBHC staff. These services may include, but are not limited to: mental health counseling, routine medical exams, naturopathy, sports physicals, well-child or teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, dental and fluoride treatment services. SBHC staff encourage family involvement in the care they provide to students. However, if I am unable to be present, authorization is given for my child to receive services in my absence. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Neighborcare Health SBHC staff. This authorization does not allow services to be rendered without the student's consent, unless she/he is unable to consent. Neighborcare Health is committed to creating a health care home that includes medical, dental and mental health care and Neighborcare Health encourages long-term relationships between patients and providers. Neighborcare Health collaborates with other providers in the community that may also be seeing the patients we serve to ensure care is coordinated.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist; for example:
1. Permission is given by the patient or parent/guardian through a signed release of information form.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under the age of 18.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care providers at the SBHC, including exchange of information between the mental health therapist, nurse practitioner or physicians assistant and the school nurse, for the purpose of providing the best care for the above named student. To facilitate coordination of care, the student's SBHC medical record will be accessible to Neighborcare Health staff at the SBHC. Consent is granted for the school nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the medical provider of the SBHC.

Students may also receive health services independently at any of Neighborcare Health's medical or dental clinics. With this consent, services can be received at any Neighborcare Health medical and dental clinic. To see a list of clinic locations, please visit our website at Neighborcare.org. To schedule an appointment, call the Neighborcare Patient Contact Center at 206-548-5710.

Consent is authorized for services provided by Neighborcare Health during the length of time the student is enrolled in a school with a Neighborcare Health SBHC or for the length of time services are provided at another Neighborcare Health clinic. Withdrawal of this consent can be done at any time by writing to the SBHC.

Parent/Guardian Signature: _____Date: ____/___/_____

Name of Legally Responsible Guardian (Print):_____Relationship:_____

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.washingtonlawhelp.org and search "Minor Consent".

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Dental Screening Consent

School: _____

Classroom #: _____

(For Administrative Use) MRN: _____

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.

What is a dental screening?

A Neighborcare dental provider will look at your 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 or Guardians, please fill out the information below and sign 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 Birth (mm/dd/yy)

Address: _____ City: _____ Zip: _____

Phone #: _____

Do you prefer to be contacted in a language other than English? ☐No ☐Yes *If yes, what language*? _____

How would you like to receive your child's dental evaluation results?
☐ Please give them to my child at school to take home. ☐ Please mail them to the address listed above.

When did your child last see a dentist?
☐ Less than 6 months ago ☐ Less than 2 years ago ☐ Never
☐ Less than 1 year ago ☐ More than 2 years ago

Does your child have a regular dentist? ☐No ☐Yes *If yes, where*? _____

Would you like help finding a dentist for your child? ☐Yes ☐No

This program is without cost to you, but your health insurance company may be billed for services. Please complete the insurance section of this form to ensure we have the most current information. Public insurance plans generally cover the entire fee of the screening. If any costs are not covered by insurance, they will be covered by grants. No out of pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's 2 yearly dental exams.

Please list your Apple Health or other Dental Insurance information below:

Dental Insurance Name: _____

Subscriber Name: _____

Relationship: _____ Subscriber Gender: _____ Subscriber DOB: ___/___/___

By signing this form you agree to 2 dental screenings and fluoride varnishes.

_____ _____
Signature of Parent or Guardian **Date**

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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.

1. **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:
   (1) 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.