September 2015

Dear Parents/Guardians:

Did you know that your son or daughter can get **Health Care** at school? Roosevelt High 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 55,000 people in Seattle each year.

The SBHC offers a teen 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 medications
- Sports physicals
- Reproductive health care
- Mental, social, and emotional health care
- Oral health care
- 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)
- ☐ Release of Education Records (pg. 5)

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.

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 Roosevelt High School SBHC receives support from the Families and Education Levy, but this funding does not fully cover the program's operating costs so the SBHC will bill insurance when possible. Please complete the insurance section of the registration form to ensure that we have your most current insurance information.

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

Roosevelt High 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 Roosevelt High School SBHC at (206) 527-8336.

Sincerely,
Brian Vance
Principal

If you would like a translated copy of the enclosed information visit www.neighborcare.org or call the School-based Health Center.

School-Based Health Centers

Health History Form

In order to help us provide the best care for your child, please fill this out as completely as possible. To schedule an appointment, please call the School-Based Health Center (phone number is on the letter). Thank you.

Student's Name:____________________ (First) ____________________ (Last) Date of Birth: ____/____/____

____________________ (Printed Name of Person Completing Form) ____________________ (Relationship to Student (if not self) ____________________ (Date Form completed)

QUESTIONS ABOUT YOUR CHILD:

☐ Yes ☐ No Does your child have a Primary Care Doctor or Clinic? If Yes, please provide:
Provider 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 have any MEDICATION allergies? 1)__________ 2)__________ 3)__________
☐ Yes ☐ No Does your child have allergies to anything else? (foods, dust mites, etc.)
If Yes, please List: 1)__________ 2)__________ 3)__________
☐ Yes ☐ No Does your child take regular medications? (include vitamins and over-the-counter medications)

Medication	Dosage	Reason
1. __________	__________	__________
2. __________	__________	__________

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

Chronic or Ongoing Health Problems:

☐ Vision Problems ☐ Diabetes ☐ Hearing Problems/Ear Infections
☐ Asthma ☐ Anemia ☐ Underweight or overweight
☐ Heart Problems ☐ High Blood Pressure ☐ Dental Decay/Teeth Problems

Acute or Urgent Health Problems, including Infections:

☐ Bone or Joint Injury ☐ Chickenpox ☐ Serious accident or fall
☐ Bladder or Kidney Infection ☐ Fainting or Passing Out ☐ Tuberculosis or TB Infection

Other Concerns about Well-Being:

☐ Too much worry or stress ☐ Behavior or Anger Problems ☐ Alchohol or Drug Problem
☐ Attention Deficit Disorder ☐ Depression ☐ My Child has been threatened or harassed by someone

School or Learning Problems in This or Last School Year:

☐ Worse grades ☐ Failing grades ☐ Suspension
☐ Attendance ☐ Relationship problems with students or adults

Other Health Conditions or Special Healthcare Needs:

Describe any:____

Check all items you feel are generally true for your child:

☐My child engages in behavior that supports a healthy lifestyle; eating healthy foods, being active, and keeping safe.
☐My child has at least one adult in their life who cares about them and to whom they can go to for help.
☐My child has at least one friend or a group of friends with whom they are comfortable.
☐My child is helpful or active in a group in school, a faith-based organization, or the community.
☐My child is able to bounce back from life's disappointments.
☐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 or cigars?
☐Yes ☐No Do you eat meals together as a family?
☐Yes ☐No Is there a gun in your home?

FAMILY HEALTH HISTORY: (check all that apply)	Father	Mother	Other Relative (Aunt, Uncle, Grandmother, Grandfather)
Asthma	☐	☐	☐
Cancer; Identify Type	☐	☐	☐
Diabetes	☐	☐	☐
Heart Attack or Stroke before age 55	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Alcohol or Drug Problems	☐	☐	☐
Depression or Anxiety	☐	☐	☐
Sudden or Unexplained Death	☐	☐	☐
Blood Clots	☐	☐	☐
Tuberculosis (TB Infection)	☐	☐	☐
Physical, Sexual or Other Abuse	☐	☐	☐
Other Illness or Conditions explain:__________	☐	☐	☐

** When your child comes in for care, we will ask them to complete a risk assessment that will include family health history.*

NEIGHBORCARE HEALTH REGISTRATION FORM - School-Based Health Centers

Please help us serve you better by providing the following confidential information

Please complete a new Registration Form every year so we have the most current information on record.

Student's Name: Last (Sr. Jr.) First: Middle: | Other Names Used: *(If applicable)* | Nickname:

Student's Social Security Number: | Student's Date of Birth: ____/____/____ | Student's Sex (Check one): ☐MALE ☐FEMALE

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

City: State: Zip:

Phone *(Student)*:____________________________(Cell/Other)

E-mail *(Student)*:____

Parent, Guardian, or Responsibile Party:

Relationship: ☐Parent ☐Grandparent ☐Sibling ☐Other ________

Parent/Guardian Name:____

Parent/Guardian Date of Birth: ____/____/____

Parent/Guardian Gender: ☐Male ☐Female

Parent/Guardian Home Phone:______________________________

Parent/Guardian Address: ☐ Same as Student

Street:____

City:___________________________ State:_______ Zip:_______

Phone *(Parent/Guardian)*:_____________________________(Cell/Other)

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

Best way to contact me:__________________________________

IN CASE OF EMERGENCY CONTACT:

☐ Same as Parent/Guardian Information

Name___________________________________DOB_______________

Relationship_____________Telephone____________________(Cell/Other)

____

Address City St Zip

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

☐ AMHARIC	☐ HMONG	☐ SAMOAN
☐ ARABIC	☐ KOREAN	☐ SOMALI
☐ CAMBODIAN/KHMER	☐ LAOTIAN	☐ SPANISH
☐ CANTONESE	☐ MANDARIN	☐ TAGALOG
☐ ENGLISH	☐ MIEN	☐ THAI
☐ FARSI	☐ OROMO	☐ TIGRINYA
☐ FRENCH	☐ RUSSIAN	☐ VIETNAMESE

☐OTHER Language:_____________________

Student Status

Student ID:____________________ Grade:__________________

School:___________________ Family Size:______________

Family Adjusted Gross Income:_______________________

ADDITIONAL QUESTIONS:

Disabled/Handicapped: Does the patient have 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.______________________
Total Number of Children <18: Number of children in the household under age 18.______________________
Household Status: Patient lives with: ☐ Single Parent (Male) ☐ Single Parent (Female) ☐ Both Parents
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
Veteran Status: ☐ YES ☐ NO

Student Race:

☐AMERICAN INDIAN/ALASKA NATIVE	☐NATIVE HAWAIIAN
☐ASIAN	☐OTHER PACIFIC ISLANDER
☐BLACK/AFRICAN AMERICAN	☐DECLINE TO SPECIFY
☐MORE THAN ONE RACE	☐WHITE

Student Ethnicity:

☐HISPANIC OR LATINO
☐NOT HISPANIC OR LATINO

☐No insurance; please contact me with additional information on coverage options

☐No insurance

Primary Insurance Name:____

Subscriber Name:____________________________ Relationship:___________ Subscriber Gender:______ Subscriber DOB: ___/___/___

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 mis-representation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical/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 health problems. I understand that the medical care may be given by a Physician, Nurse Practictioner, Physician Assistant 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 providers who have rendered services to me. I agree to pay all charges that are not paid in full by assigned insurance. 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 providers 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. Neighborcare Health must have a 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 a 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 and encouraging long-term relationships between patients and providers that includes medical, dental and mental health care. Neighborcare Health collaborates with other providers in the community that may also be seeing 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.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under 18 years old.
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 of the following other Neighborcare Health medical clinics:

High Point Medical-Dental Clinic: 206-461-6966
45th Street Medical-Dental Clinic: 206-633-3350
Meridian Medical Clinic: 206-296-4990
Columbia City Medical Clinic: 206-461-6957
Central District Dental Clinic: 206-461-7801

Rainier Beach Medical-Dental Clinic: 206-722-8444
Greenwood Medical Clinic: 206-782-8660
Lake City Medical Clinic: 206-417-0326
Georgetown Dental Clinic: 206-461-6943

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.

Student Signature: ____Date: ____/___/_____

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

Name of Legally Responsible Guardian (Print):______________________________Relationship:____________

IMPORTANT ADDITIONAL INFORMATION

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 may independently receive drug and alcohol services and mental health counseling from age 13 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 over, and parent/guardian consent for students age 12 and under, is legally required for release of information about alcohol and drug or mental health counseling.

Community Based Organization
Parent/Guardian Consent Form
2015-2016 Approval

Public Health – Seattle & King County
School-Based Partnerships Program
401 5th Ave #1000
Seattle, WA 98104
206.263.8350

Neighborcare Health at
Roosevelt High School
1410 NE 66th st
Seattle, WA 98115
(206) 527-8336

UW Department of Psychiatry &
Behavioral Sciences
1959 NE Pacific Street
Box 356560
Seattle, WA 98195-6560
206-543-3750

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 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. The University of Washington Department of Psychiatry and Behavioral Science will only be granted access to the above educational records for the purpose of maintaining a secure database to store the data. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District's School & Community Partnership Department, MS: 32-159 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, 2016. 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 card, official school mailing, or by contacting your student's school**

For more information please refer to http://communitypartnerships.www.seattleschools.org