


neighborcare health
 School-Based Health Center Program Consent for Health Services

Neighborcare Health must have a signed Consent Form from a parent or legal guardian before providing services to your student, except in situations where federal and/or state laws allow student to access such treatment without parent/guardian consent. Any individual may independently access reproductive health care at any age and they may independently receive drug and alcohol services and mental health counseling starting at age 13. If necessary, the Health Center will inform students of options for outside care and will assist the student in discussing these issues with parents/guardians.

By signing this Consent Form, you are also granting permission for the school nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the Nurse Practitioner of the Health Center. If this is not acceptable, please indicate so in writing on this form.

I hereby request and authorize

Student's First Name	Middle Initial	Last Name	Birthdate
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to receive any and all health care services available from and deemed necessary by the staff of the Health Center and it's associated provider agency. These services may include, but are not limited to, mental health counseling, routine medical exams, naturopathy, sports physicals, well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and X-rays and dental screening. Consent is specifically given for care in the event the above named student presents him/herself for treatment 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 Health Center and its staff. This authorization does not allow services to be rendered without the student's consent, unless s/he is unable to do so.

With your written authorization, your adolescent may also receive medical services independently at one of Neighborcare Health's medical clinics. I grant permission for my adolescent to receive medical services independently at one or more the following Neighborcare Health medical clinics—(please check one or more)

- High Point Medical Clinic
 45th Street Medical Clinic
 Rainier Park Medical Clinic
 Rainier Beach Medical Clinic
 Greenwood Medical Clinic

Signature of parent/guardian _____

For students with Public insurance (medical coupons): Would you like information about making Neighborcare Health your child's health care home (includes dental care). YES ___ NO ___

When consent is provided for care, all information is kept confidential, except in the following circumstances:

- The student gives permission through a signed release of information
- S/he indicates risk of imminent harm to self or others
- S/he has a life threatening health problem and is under the age of 18
- There is reason to suspect abuse or neglect
- Evidence of certain communicable diseases, requiring a report to public health authorities

Consent is given to share necessary information with all health care providers at the Health Center, including exchange of information between the mental health counselor, nurse practitioner and the school nurse, for the purpose of providing the best care for the above-named student.

I also acknowledge that I have received the Neighborcare Health Notice of Privacy Practices that describes how my health information may be used and disclosed and how I may access my information.

I understand the student's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), and alcohol/drug or mental health counseling. I understand, however, that parents/guardians will be informed if Health Center staff believes the student is a danger to him/herself or to others.

Consent for services are authorized for the length of time the student is enrolled in a school with a Health Center. You may choose to withdraw this consent at any time by writing to the Health Center that serves the student. Should you elect to not sign your adolescent up for Health Center services, s/he may still receive services from the school nurse.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



Dear Parents/Guardians:

Did you know that your son or daughter can get **HEALTH CARE** at the **Madison Wellness Center**? The Wellness Center is located at Madison Middle School and is operated by Neighborcare Health, a community health center with funding support from the City of Seattle's Families and Education Levy.

The Wellness Center, which is staffed with a Physician Assistant and two Mental Health Counselors, provides all the services (and more) that your family doctor provides and does so in a teen friendly setting. These services include mental health counseling, medical check ups, routine physicals, sports physicals, reproductive health care, treatment for acute and chronic illness, immunizations, vision and hearing screening, dental referral, lab tests and pharmaceuticals. We also provide preventive education on tobacco, alcohol and other drug use, injuries and violence. Students have the option to select Neighborcare Health as their health care home and access additional health care services including dental care.

The Wellness Center is open every day during and after school so your son/daughter can be seen at a time that is convenient for his/her schedule.

To be seen, you need to enroll your son/daughter in the Wellness Center by completing and signing the enclosed registration, consent and health history forms, and returning them to the Wellness Center.

Support from the Families and Education Levy does not cover the entire cost of the Wellness Center. If you have health insurance, we ask that you complete that section of the registration form so that we can bill your insurance company. Public insurance (medical coupons) will cover the entire fee for your student's services at the Wellness Center. However, private insurance company rules may require some out of pocket cost for services for students with private insurance coverage.

If you do not have health insurance, we would be happy to help you get signed up if you qualify. All you need to do is indicate that you have "no insurance" under the insurance section on the registration form and let us know that you would like a Medicaid application.

WE SERVE STUDENTS REGARDLESS OF ABILITY TO PAY.

Madison Middle School is fortunate to have the Wellness Center and I hope you will take advantage of this resource for your son/daughter. If you would like more information or need assistance with any of the paperwork, **please call the Madison Wellness Center at (206) 933-7842.**

Sincerely,

Jill Hudson
Principal, Madison Middle School

NEIGHBORCARE HEALTH
School-Based Health Center Program

Adolescent Health History Form

Student's Name _____ Date of Birth _____ Date Form Completed _____

Signature of Person Completing Form _____

If he or she needs to be seen at the Madison Wellness Center PLEASE CALL (206) 933-7842

PERSONAL HEALTH HISTORY

Has s/he ever had any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcohol/drug problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (Jaundice) | <input type="checkbox"/> Serious accident |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Knee or ankle injury | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Learning disability/ADD | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental/emotional problem | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Head/neck injury | <input type="checkbox"/> Positive TB skin test |
| <input type="checkbox"/> Broken bone(s) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure (epilepsy) | |
| <input type="checkbox"/> Other major illnesses, operations, hospitalizations, injuries or conditions (describe and give year) _____ | | | |

Are you worried about your adolescent with regards to the following issues?

- | | | | | | |
|-------------------------|--|-------------------------------|--|-----------------------------|--|
| › Progress in school | <input type="checkbox"/> yes <input type="checkbox"/> no | › Alcohol or drugs | <input type="checkbox"/> yes <input type="checkbox"/> no | › Riding with drivers under | <input type="checkbox"/> yes <input type="checkbox"/> no |
| › Friends/relationships | <input type="checkbox"/> yes <input type="checkbox"/> no | › Diet/weight | <input type="checkbox"/> yes <input type="checkbox"/> no | the influence | <input type="checkbox"/> yes <input type="checkbox"/> no |
| › Communication | <input type="checkbox"/> yes <input type="checkbox"/> no | › Self esteem | <input type="checkbox"/> yes <input type="checkbox"/> no | › Smoking cigarettes | <input type="checkbox"/> yes <input type="checkbox"/> no |
| › Discipline | <input type="checkbox"/> yes <input type="checkbox"/> no | › Sexual health or behavior | <input type="checkbox"/> yes <input type="checkbox"/> no | › Chewing tobacco | <input type="checkbox"/> yes <input type="checkbox"/> no |
| › Moodiness | <input type="checkbox"/> yes <input type="checkbox"/> no | › Driving under the influence | <input type="checkbox"/> yes <input type="checkbox"/> no | › General health | <input type="checkbox"/> yes <input type="checkbox"/> no |

Have there been stresses or big changes in the family recently? yes no If yes, please explain _____

Has s/he had a physical exam within the past 2 years? yes no Has s/he had a dental visit in the past year? yes no

Is s/he allergic to any medications? yes no If yes, please explain _____

MEDICATIONS None

Include birth control pills and non-prescription items such as vitamins, pain medication, laxatives, aspirin and herbs.

<u>Medication/Drug</u>	<u>Dosage</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY

Has s/he had a Tetanus booster in the past 10 yrs? yes no

▪ If yes, what year? _____

Has s/he had the series of 3 Hepatitis B immunizations? yes no

Has s/he had the series of 2 Hepatitis A immunizations? yes no

Has s/he had Chicken Pox or the immunization? yes no

FAMILY HEALTH HISTORY

Who does the student live with? (Please specify persons by relationship) _____

How many brothers does s/he have? _____ sisters? _____

Is s/he adopted? yes no

For each illness below, please tell us if a family member (grandparent, parent, aunt/uncle, sibling) has had the illness.

	<u>NO</u>	<u>YES</u>	<u>If yes, who?</u>		<u>NO</u>	<u>YES</u>	<u>If yes, who?</u>
› Alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	› Heart attack before age 55	<input type="checkbox"/>	<input type="checkbox"/>	_____
› Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	› High cholesterol needing medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
› Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	› High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
› Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	› Stroke before age 55	<input type="checkbox"/>	<input type="checkbox"/>	_____
List type _____				› Sudden death	<input type="checkbox"/>	<input type="checkbox"/>	_____
› Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	› Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
› Drug problems	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Other illnesses or conditions (explain) _____

PLEASE CONTINUE TO NEXT PAGE →

FOR CLINIC USE ONLY
Reviewer/Date _____
Reviewer/Date _____
Reviewer/Date _____

FOR OFFICE ONLY:

Acct # _____
Initial _____ Date _____



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

Have you previously registered with this School Based Health Center? YES NO

Print Student's Name _____ Female Male
(Last) (First) (Middle)

Address _____ Home phone _____
(Street) (City) (State) (Zip)

SS# _____ Birth Date _____ Student ID _____ Grade _____

Parent/Guardian _____ Home Phone _____ Relationship _____
Message Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information Completion of the insurance information below is **required**.

Does the student have health insurance? Yes No If No, would you like a Healthy Kids Now! Application? Yes No

If yes, which plan type? Private/Commercial Medicaid/Healthy Options Basic Health Plan

Insurance Company and Plan Name _____ Group or Medicaid Number _____

Policy Number (include alpha prefix, if applicable; example ZKR1234567) _____

Insurance Company Address _____ Phone _____

Policy Holder's Name _____ Birth Date _____ SS# _____

Relationship to Student _____

Are you interested in learning more about Washington State-sponsored health insurance programs? Yes No

Race

Which of the following best describes the student's race? (Please check only one)

- | | | |
|--|--|--|
| <input type="checkbox"/> African American/African Native | <input type="checkbox"/> Caucasian/White | <input type="checkbox"/> Pacific Islander--Native Hawaiian |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Pacific Islander--Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Multi-Racial | <input type="checkbox"/> Other |

Other Information

- Does the student live in public housing? Yes No
- Is the student homeless? Yes No If yes, what is the living arrangement?
 Doubling up Transitional Shelter Street Other
- Is the student or any member of the family a migrant or seasonal farm worker? Yes No
- Does the student have an ongoing disability that would stop her/him from doing daily activities? Yes No
- Is the student an immigrant or refugee or new arrival in this country? Yes No
- What is the number of family members reported on the federal income tax return? _____
- What is the number of family members under age 18, including the student? _____
- Does the student live in a single parent, non-partnered household? Yes No
- What primary language is spoken at home? _____

Does the student have a doctor (or a clinic)? Yes No If yes, please provide name and phone number _____

I certify that the information reported above is correct. I hereby authorize Neighborcare Health to bill my insurance company for any services provided by Neighborcare Health. I authorize Neighborcare Health to release to my insurance company any information needed to determine the benefits payable to related services.

Signature _____ Date _____ Relationship to Student _____

PLEASE CONTINUE TO NEXT PAGE →