Garfield High Teen Health Center

Full Registration Packet

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While Seattle Public Schools endeavors to only post documents optimized for accessibility, due to the nature and complexity of some documents, an accessible version of the document may not be available. In these limited circumstances, the District will provide equally effective alternate access.

For questions and more information about this document, please contact the following:

Garfield Teen Health Center
https://garfieldhs.seattleschools.org/services/teen_health_center
206.860.0480

The Garfield Teen Health Center (GTHC/THC) is a school-based health clinic operated by Seattle Children's staff. The GTHC is sponsored by Odessa Brown Children's Clinic, Seattle/King County's Public Health Department, and Seattle Public Schools. We are located inside of Garfield High School, on the first floor, in room 102.

Welcome to the Doghouse Garfield student & family,

The Garfield Teen Health Center (GTHC/THC) is a school-based health clinic operated by Seattle Children's staff. The GTHC is sponsored by Odessa Brown Children's Clinic, Seattle/King County's Public Health Department, and Seattle Public Schools. We are located inside of Garfield High School, on the first floor, in room 102.

We provide medical care, nutritional services, and mental health counseling to students enrolled at Garfield. These services include, but are not limited to physical exams, immunizations, health education, nutrition consultations, mental health counseling, and academic concerns. **All services provided are absolutely free** to students thanks to funding from our sponsors and the City of Seattle's Families and Education Levy. Not only is it at no-cost to families, it's also a convenient way for students to receive the services they need to succeed in school and in life. For more information on our clinic, please find us on the Garfield High School website, under the 'Resources and Services' tab, from there 'Teen Health Center'.

We have provided the registration/consent form as part of your student's "First Day Packet". Our clinic requires consent forms to be updated each school year. Students can also retrieve the consent forms available inside the clinic.

If your student needs an **immediate** appointment with our clinic, please have your student **bring the consent form/packet directly to the Teen Health Center** during the first weeks of school. After bringing in the consent form, your student will become part of the Seattle Children's system and be able to schedule an appointment that meets their health needs. If your student **doesn't need an immediate** appointment, but would like to access our services at any time during the school year, the consent packet can be completed with the rest of the documents in the student packet and **returned to the Main Office.** The QR code below can also be used for scheduling appointments.

Our team looks forward to meeting your student and having a healthful school year!

Best,
Garfield Teen Health Center Staff:
Amy Andersen, Nurse Practitioner
Oriana Souers-Dilley, Nurse Practitioner
TBD, Mental Health Counselor
Sandra Walker, Psychiatrist
Ayanna Ford, Clinic Coordinator
Phuong Truong, Nutritionist

Garfield
Teen Health Center

Dear Parents or Guardians of Garfield students:

The Garfield Teen Health Center (GTHC) is sponsored by the Odessa Brown Children's Clinic, the Seattle/King County Public Health Department and Seattle Public Schools with additional funding from the City of Seattle's Families and Education Levy. Medical and mental health professionals from Seattle Children's Hospital and the Odessa Brown Children's Clinic provide services and consultations. Students, school faculty, school administration, parents and community organizations have participated in building a quality health care program for Garfield students.

The services that the clinic offers your child include (but are not limited to):

- Physical exams and health assessments (including sports physicals and other routine exams)
- Immunizations
- Diagnosis and treatment of illness and injuries
- Assessment and counseling related to mental health
- Nutrition consultations
- Family planning and sexually transmitted disease services
- Health education activities
- Assistance in obtaining health insurance

Each student must provide full parental consent in order to receive comprehensive services.
Parental consent requires completion of the attached registration form and the signature from the student's legal guardian. All services at GTHC are provided free of charge. GTHC's primary focus is to make health care available to students who do not have health insurance coverage or who have not seen a primary care provider recently.

We are proud of the GTHC and its ability to provide high quality school-based health care to students. We believe this is a unique opportunity for students to learn how to care for their health. Join us in this effort.

Please complete and sign the attached consent form and return it to the Teen Health Center at Garfield High School. Feel free to stop in and meet the clinical staff or call if you have questions about the clinic and its services.

Please sign consent on the other side.

Garfield Teen Health Center
400 23rd Ave, Room 102
Seattle, WA 98122
Phone: 206.860.0480 Fax: 206.860.0680

ODESSA BROWN CHILDREN'S CLINIC

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

52713

GARFIELD TEEN HEALTH CENTER CONSENT

PATIENT LABEL

Archive Information

School-based Health Centers
Consent for Health Services

School-based health centers located in Seattle Public Schools must have a signed consent from a parent or legal guardian before providing services to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. If the youth 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 Youth's name: _____ _____
First Name Middle Initial Last Name Birthdate

School:_____Graduation year: _____

receive health care services available from and deemed necessary by the staff of the SBHC. These services include, but are not limited to, such procedures as well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and x-rays. Consent is also given for referral of care and if needed, emergency transportation to other providers, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the Center and its staff. This authorization does not allow services to be rendered without the youth's consent, unless s/he is unable to provide consent.

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

1. The client gives permission through a signed release of information.
2. If s/he indicates a risk of imminent harm to self and others.
3. S/he has a life threatening health problem and is under the age of 18 years.
4. There is a reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

CONSENT TO PARTICIPATE IN TELEHEALTH CONSULTATION AND TREATMENT

I, patient/parent/authorized representative, understand that telehealth* is a way to receive healthcare from a provider at a distance through video visits, secure messaging, phone consultations, remote monitoring, and other forms of communications. Telehealth services may include a patient consultation, diagnosis, treatment recommendation, mental health therapy, prescription, and/or a referral to in-person care, as determined clinically appropriate by the provider. Seattle Children's may deliver telehealth services through its online patient portal and through other enabling technologies in accordance with all applicable laws. The technologies incorporate network and software security protocols to protect the confidentiality and integrity of personal health data. All existing confidentiality protections under federal and state law apply to information disclosed during this telehealth encounter.

I understand:

- A benefit of telehealth is that it allows me/the patient to remain in a preferred location while receiving healthcare.
- The provider will determine whether the condition being diagnosed and/or treated is appropriate for a telehealth encounter.
- I/the patient have the option to consult with a provider in person by traveling to their location.
- I will be given information about the provider's credentials (doctor,nurse practitioner or other type of provider).
- During the telehealth encounter:
  - Details of my and/or the patient's healthcare information may be discussed.
  - Physical examination of me/the patient may take place.
  - Nonmedical personnel may be present to operate technologies and I may ask to be informed of their presence and role.
- All electronic communications and medical reports resulting from the telehealth encounter are part of my/the patient's medical record. All existing laws regarding my/the patient's access to healthcare infomation and copies of healthcare records apply to this telemedicine encounter.
- Providers do not address medical emergencies through telehealth. I will be directed to dial 9-1-1 immediately in the event of a medical emergency.
- Possible risks of using telehealth include:
  - Limitations of the physical exam conducted via telehealth.
  - Even after a telehealth encounter, the provider may decide that an in-person visit is still necessary and may refer me/the patient to in-person care.
  - Technical problems may interrupt or stop the encounter before it is completed.
  - Someone could overhear me/the patient, or the information discussed during the telehealth encounter.
  - The technology could be compromised.

I may withhold or withdraw consent to the telehealth encounter at any time without affecting my/the patient's right of future care or treatment. I have been advised of all the potential risks, consequences and benefits of telehealth provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

*Telemedicine and/or telemental health consultation or treatment services.

PATIENT LABEL

Garfield
Teen Health Center

Consent for services is authorized for the length of time the youth is enrolled in Garfield High School. I may choose to withdraw the consent at any time by writing to the Center that serves the youth.

Youth Signature:_____Date:_____Time:_____

Parent/Guardian Signature:_____Date:_____Time:_____

Name/Relationship of Legally Responsible Guardian (print): _____

FOR YOUR INFORMATION

Under Washington State law, youth may Independently access reproductive health care at any age without parent/guardian consent (RCW 3.02.100(1 and 2)). They may Independently receive drug and alcohol services and mental health counseling from age thirteen (RCW 70.96A.095, RCW 70.96A.0097, RCW 71.34.530, and RCW 71.34.500) and care for STDs from age fourteen (RCW 70.24.110) without parent/guardian consent. The School-Based Health Center encourages each youth to involve his/her parents or guardians in health care decisions whenever possible.

If necessary, the SBHC will inform youth of options of and assist youth in accessing outside care. The SBHC will assist the youth in discussing these situations with parents/guardians.

Youth'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 and drug or mental health counseling.

Archive Information

Student Registration Form (please print)

Student's Last Name:	First Name:	Middle Name:
Street:	City:	State/Zip Code:
Birth Date:	Social Security Number:	Student ID#:
Sex: _____Male_____Female_____Transgender_____Other	Current Grade/Year: ___9____10____11____12	Graduation year:
Parent/Guardian Name:	Home Phone #:	Work phone/Cell phone #:
***Allergies (please list and describe reaction).**		
Emergency Contact name:	Relationship to Student:	Emergency Contact Phone #:
Primary Care Provider's name:	Primary Care Provider's Phone #:	
Family e-mail address:	Student's preferred Language:	Families preferred Language:

Race/Ethnicity

Which of the following best describes the student's race?

____African-American____African Native_____American Indian/Alaska Native_____Asian____Caucasian ____Other/Multi

Which of the following best describes the student's ethnicity (check all that apply):

___Anglo/western European	___Samoan	___Ethiopean	___Somali	___Eritrean	___Other African Native
___Cambodian	___Chinese	___Filipino	___Korean	___Vietnamese	___Japanese
___East Indian	___Other Asian	___Eastern European	___Hispanic/Latino	___Middle Eastern	Other:

Housing Information

Is the student homeless?_____Yes_____No. If yes, please list the city, state and zip code of last permanent residence.

Does the student live in public housing?_____Yes_____No

Does the student live in a single parent, non-partnered household?_____Yes_____No

How many family members under the age of 18 live in the student's residence (Including the student)? ____

Other Information

Some patients and/or their family members are being hurt or threatened by someone they love. Is this happening to you?_____No____Yes. (If yes, please explain)

Is violence at home a concern for the student?_____Yes_____No

Is the student an immigrant or refugee or a new arrival to the U.S.?_____Yes_____No

Is the student employed?_____Yes_____No

Does the student have an ongoing disability that would stop her/him from doing daily activities?

____Yes_____No (If yes, please explain)

Is the student eligible for the Free or Reduced Lunch Program?_____Yes_____No____I don't know

Insurance Information

Does the student have insurance?____Yes_____No

If yes, please complete the information below.

If no, are you interested in learning more about free or low-cost health insurance?_____Yes_____No

Policy Holder's Name:	Policy Holder's Birth date:	Policy Holder's Social Security Number:
Name of Insurance Company (including Medicaid, DSHS programs):	Policy Number:	Policy Effective Dates:

ADOLESCENT PREVENTIVE SERVICES: PARENT/GUARDIAN QUESTIONNAIRE

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   D Yes D No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken

3. Has your adolescent ever been hospitalized overnight?
   D Yes D No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem

4. Has your adolescent ever had any serious injuries?
   D Yes D No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
   D Yes D No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	D	D		Headaches/migraines	D	D	
Allergies/hayfever	D	D		Low iron in blood (anemia)	D	D	
Asthma	D	D		Pneumonia	D	D	
Bladder or kidney infections	D	D		Rheumatic fever or heart disease	D	D	
Blood disorders/sickle cell anemia	D	D		Scoliosis (curved spine)	D	D	
Cancer	D	D		Seizures/epilepsy	D	D	
Chicken pox	D	D		Severe acne	D	D	
Depression	D	D		Stomach problems	D	D	
Diabetes	D	D		Tuberculosis (TB)/lung disease	D	D	
Eating disorder	D	D		Mononucleosis (mono)	D	D	
Emotional disorder	D	D		Other: _____	D	D	
Hepatitis (liver disease)	D	D					

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   D Yes D No D Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	D	D	D		
Arthritis	D	D	D		
Birth defects	D	D	D		
Blood disorders/sickle cell anemia	D	D	D		

Archive Information

ADOLESCENT PREVENTIVE SERVICES: PARENT/GUARDIAN QUESTIONNAIRE

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	D	D	D	_____	_____
Depression	D	D	D	_____	_____
Diabetes	D	D	D	_____	_____
Drinking problem/alcoholism	D	D	D	_____	_____
Drug addiction	D	D	D	_____	_____
Endocrine/gland disease	D	D	D	_____	_____
Heart attack or stroke *before* age 55	D	D	D	_____	_____
Heart attack or stroke *after* age 55	D	D	D	_____	_____
High blood pressure	D	D	D	_____	_____
High cholesterol	D	D	D	_____	_____
Kidney disease	D	D	D	_____	_____
Learning disability	D	D	D	_____	_____
Liver disease	D	D	D	_____	_____
Mental health	D	D	D	_____	_____
Intellectual or Developmental Disability	D	D	D	_____	_____
Migraine headaches	D	D	D	_____	_____
Obesity	D	D	D	_____	_____
Seizures/epilepsy	D	D	D	_____	_____
Smoking	D	D	D	_____	_____
Tuberculosis/lung disease	D	D	D	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

D Both parents in same household
D Mother
D Father
D Other adult relative
D Stepmother
D Stepfather
D Guardian
D Brother(s)/ages _____
D Sister(s)/ages _____
D Other _____
D Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

D Marriage
D Separation
D Divorce
D Loss of job
D Move to a new neighborhood
D A new school or college
D Births
D Serious illness
D Deaths
D Other _____

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	D	Guns/weapons	D
Physical development	D	School grades/absences/dropout	D
Weight	D	Smoking cigarettes/chewing tobacco	D
Change of appetite	D	Drug use	D
Sleep patterns	D	Alcohol use	D
Diet/nutrition	D	Dating/parties	D
Amount of physical activity	D	Sexual behavior	D
Emotional development	D	Unprotected sex	D
Relationships with parents and family	D	HIV/AIDS	D
Choice of friends	D	Sexual transmitted diseases (STDs)	D
Self image or self worth	D	Pregnancy	D
Excessive moodiness or rebellion	D	Sexual identity (heterosexual/homosexual/bisexual)	D
Depression	D	Work or job	D
Lying, stealing, or vandalism	D	Other: _____	D
Violence/gangs	D		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? D Yes D No

ADOLESCENT PREVENTIVE SERVICES:
PARENT/GUARDIAN QUESTIONNAIRE

PATIENT LABEL

Community Based Organization
Parent/Guardian Consent Form
2021-2022 Approval

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

[Garfield Teen Health]
[Odessa Brown Children's]
[2101 E. Yesler Way Suite 100]
[206-860-0480]

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, [Odessa Brown] 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, 2022. 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's School

***Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student's school*