November 2012

Dear Parents/Guardians:

Did you know that your son or daughter can get **Health Care** right at school? I am excited to announce that beginning in late November, Roxhill Elementary School will have a School-Based Health Center (SBHC) that is located inside the building. This is a new service offered to students at Roxhill, and will provide them with high quality medical and mental health services by licensed providers. The SBHC is operated by Neighborcare Health, a community health center network of 20 medical, dental and school-based health centers in Seattle, serving more than 50,000 patients each year.

The School Based Health Center offers a youth-friendly setting and all the services (and more) of a family doctor. The SBHC will provide:

- Quality care on-site by a Licensed Medical or Mental Health Provider
- Appointments before, during, and after school
- Evaluation and treatment of common health problems
- Immunizations, lab tests and medications
- Sports physicals
- Preventative health care, including education on nutrition, physical activity, injuries and violence, and oral health services
- Assistance with health insurance eligibility and enrollment
- A health care home, including coordination of additional care at other Neighborcare Health clinics offering medical and dental services
- Referrals to other health care providers as needed

To use this service, please complete and sign the attached consent, release of information, registration and health history forms and return them to the School Based Health Center. They can be dropped off in person at the SBHC or the main office. The school nurse is still available to see all children, regardless of their registration with the SBHC.

A completed Release of Information form allows your child's school records to be shared with Neighborcare Health. If your child is under 18 years old, the school needs your permission to share school records with the SBHC. Access to school records enables Neighborcare Health to work with teachers and staff to improve student learning, attendance, grades and behavior. If you agree to allow the school to share this information with the SBHC, please sign and return the Release of Information form.

The Roxhill SBHC receives support from the Families and Education Levy, but the funding does not cover the entire cost. Your health insurance company may be billed for services. Please complete the insurance section of the registration form to ensure we have the most current information. Public insurance plans generally cover the entire fee for your student's services at the SBHC. However, if you have private insurance your plan may not cover the entire cost of care and insurance rules may require that Neighborcare bill for some out of pocket expense.

If you do not have health insurance, staff at the SBHC can help you enroll. Please check the "No Insurance: please contact me with additional information" box on the registration form and we will follow up with you. You can also call the SBHC or send an email to sbhceligibility@neighborcare.org. **Neighborcare Health is committed to serving all patients regardless of ability to pay**.

I hope you will take advantage of this resource for your son/daughter. The SBHC is committed to providing family-centered care for your child, and I highly encourage you to attend your child's appointments whenever possible. If you would like more information or need assistance, please call the Roxhill SBHC at (206)452-2660.

Sincerely,

Sahnica Washington
Principal

11/12 *If you would like a translated copy of the enclosed information visit neighborcare.org or call the school-based health center.*

neighborcare health
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. If you would like an appointment, please call the School-Based Health Center (phone number is on the letter). 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 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.	_____	_____	_____
3.	_____	_____	_____

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 ☐ School or Learning Problems ☐ Alchohol or Drug Problem
☐ Attention Deficit Disorder ☐ Behavior or Anger Problems ☐ Depression

Other Health Conditions: Hospital stays, surgery, problems with birth, growth, thyroid, hepatitis, cancer, trauma or abuse.

Describe:_____

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.
☐ My child is particularly good at doing certain things like math, sports, theater, cooking, or writing.
☐ My child and I have talked about the physical and emotional changes at their age.
☐ My child has a TV and/or a computer in the area where they sleep.

QUESTIONS ABOUT YOUR FAMILY:

How many people live 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 (Please Identify)
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:_____	☐	☐	☐

Release of Information
2012-2013 School Year

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

I, _____, (*parent and/or guardian of)* _____, a student at **_Roxhill Elementary _,** consent to the release of my child's education records from the Seattle School District to Neighborcare Health medical and mental health providers at the School-Based Health Center.

I understand that the educational records to be released may include, but are not limited to:

1. Name of student
2. School of student
3. Attendance
4. Assignment Grades
5. Test Scores, including MSP Scores
6. Disciplinary records

I understand that this release includes permission for the Neighborcare Health medical and mental health providers at the School-Based Health Center to access my child's academic records online, using The Source.

I understand that the purpose of sharing these records with Neighborcare Health medical and mental health providers from the School-Based Health Center is to keep my child's school-based health and mental health care providers informed of his/her academic program and progress. Neighborcare Health medical and mental health providers will work with the school, the family and the student in an effort to improve my child's success at school.

I acknowledge that I may submit a subsequent notification in writing directing the Seattle School District to no longer release information to agency staff.

This Release of Information will be valid for the 2012-2013 school year, or as long as the student is served by the agency, whichever is the lesser time length.

Seattle School District is authorized to release information to the following agency (please print clearly):

_____
Student's Name

_____
Date Signed

_____
Student **Date of Birth** & School **District ID #**

_____
Parent/Guardian's *Signature* (if youth is 17 or younger)

Agency Name, Address & Phone Number:
Neighborcare Health
Roxhill School-Based Health Center
9430 30th Ave SW
Seattle, WA 98126
206-452-2660

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:	Previous Last: *(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: County:

Phone ***(Student)***:_____(Cell/Other)
E-mail ***(Student)***:_____

IN CASE OF EMERGENCY CONTACT:
☐ Same as Parent/Guardian Information
Name_____
Relationship:_____Telephone_____(Cell/Other)

Address City St Zip

Parent, Guardian, or Responsibile Party:
Relationship: ☐Parent ☐Grandparent ☐Sibling ☐Other _____
Parent/Guardian Name:_____
Parent's/Guardian Home Phone:_____
Parent's/Guardian Address: ☐Same as Student
Street:_____
City:_____ State:_____ Zip:_____
Phone ***(Parent/Guardian)***:_____(Cell/Other)
E-mail ***(Parent/Guardian)***:_____

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

Parent/Guardian Sex: ☐Male ☐Female

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

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

OTHER Language:_____

Student Status (circle one):
Full Time Part Time Not a Student

Student ID:_____ **Grade:**_____

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 in single parent non-partnered household? ☐YES (male) ☐YES (female) ☐NO
Housing Status: ☐Doubling Up ☐Not Homeless ☐Other ☐Public Housing ☐Shelter ☐Street ☐Transitional ☐Unknown/Unreported
Farm Worker Status (Circle One): 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	☐UNREPORTED/REFUSED
☐MORE THAN ONE RACE	☐WHITE

Student Ethnicity:
☐HISPANIC OR LATINO
☐OTHER

☐No insurance; please contact me with additional information on coverage options
☐No insurance
Primary Insurance Name:_____
Subscriber Name:_____ Relationship:_____ Subscriber Sex:_____ Subscriber DOB: ___/___/___
Identification/Policy #:_____Plan # (if applicable):_____ Group # (if applicable):_____
Group Name (if applicable):_____Effective Date:____/____/____ Insurance Phone #:_____
Secondary Insurance Name:_____
Subscriber Name:_____ Relationship:_____ Subscriber Sex:_____ 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 Elementary School-Based Health Centers
Consent for Health Services

Neighborcare Health School-Based Health Centers (SBHCs) located in Seattle Public Schools 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 staff of the SBHC. These services may include, but are not limited to: mental health counseling, routine medical exams, naturopathy, sports physicals, well-child care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, dental and fluoride treatment services. 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 include 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 School-Based Health Center 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 medical services independently at one of Neighborcare Health's medical clinics. With this consent, services can be received at one of the following other Neighborcare Health medical clinics:

High Point Medical Clinic: 206-461-6966
45th Street Medical Clinic: 206-633-3350
Rainier Park Medical Clinic: 206-461-6957
Rainier Beach Medical Clinic: 206-722-8444
Greenwood Medical Clinic: 206-782-8660

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 medical clinic. Withdraw 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

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. 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. Consent from parent/guardian for students age 12 and under is legally required for release of information about alcohol and drug or mental health counseling.