

## SCHOOL HEALTH SERVICES PROGRAM

Please fill out the form below after carefully reviewing the policies and procedures governing student health services, and then sign the required consents contained in this document. This is required in order for you (if you are a student who is 18 years of age or older) or your child to participate in school health services provided to District of Columbia Public School (DCPS) students. Please submit the completed document to your child's school registrar.

Student's Personal Information   Completed by parent/guardian/student eighteen (18) years of age or older				
<b>Student Last Name:</b>		<b>Student First Name:</b>		<b>Date of Birth:</b>
<b>School or Child Care Facility Name:</b>				
<b>Home Address:</b>	<b>Apt:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Ethnic Designation:</b> <i>(check all that apply)</i> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Prefer not to answer				
<b>Race:</b> <i>(check all that apply)</i> <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer				
Parent/Guardian Information				
<b>Parent/Guardian Name 1:</b>		<b>Parent/Guardian Name 2:</b>		
<b>Phone:</b>	<b>Email:</b>	<b>Phone:</b>	<b>Email:</b>	
<b>Relationship to Student:</b>		<b>Relationship to Student:</b>		
<b>Parent/Guardian Phone:</b>		<b>Parent/Guardian Phone:</b>		
<b>Emergency Contact Name, Relationship to Student:</b>		<b>Emergency Contact Phone:</b>		
Insurance Information				
<b>Insurance Type:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None		<b>Insurance Name/ID #:</b>		
		<b>Insurance Plan:</b>		
<b>If your child does not have health insurance, would you like to be contacted by the clinical case manager for assistance with obtaining health insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Primary Care Provider Name:</b>				
<b>Primary Care Provider Organization &amp; Address:</b>				
<b>Primary Care Provider Phone:</b>				

## SCHOOL HEALTH SERVICES PROGRAM POLICIES AND PROCEDURES

- District of Columbia Public School students may receive care from a school nurse, school health suite personnel, or trained school staff in accordance with District of Columbia (District) laws and regulations and the District's Department of Health (DC Health) School Health Services Program (SHSP) policies and procedures.
- I understand in order to participate in the SHSP, I must provide consent to allow the student's medical care provider to electronically send my child's health information including, but not limited to the information in the Universal Health Certificate, to my child's school. Information regarding care provided to my child in my child's school may be shared with other District agencies for the purpose of coordinating my child's care and for District-wide data collection, for example to monitor asthma or other health trends in the District.
- My child's health information will always be stored and transferred in accordance with District and federal laws and regulations including, but not limited to the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) act and D.C. Law 18-273, the Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Official Code § 7-241 et seq.)
- A student that is eighteen (18) years of age or older, or an emancipated minor, as defined by D.C. Official Code sec. 7-1231.02 (10) may complete this form for themselves and legally consent to any school health services.
- In accordance with the Minor's Health Consent Regulation (22-B DCMR 600.7) for a minor may legally consent for the prevention, diagnosis or treatment of (1) a pregnancy or its lawful termination; (2) substance abuse, including drug and alcohol abuse; (3) a mental or emotional health condition, or (4) a sexually transmitted disease. Furthermore, parental consent is not required for the application of emergency first aid treatment or the provision of services where the health of a student is endangered.

## SCHOOL HEALTH SERVICES PROGRAM ACKNOWLEDGEMENTS AND CONSENTS

- I hereby give consent for my child’s school or school health suite personnel to provide a hearing and vision screening test if my child has not received one in the past calendar year according to their submitted Universal Health Certificate.
- I hereby give consent for the school or school health suite personnel to administer prescribed medication and/or treatment to my child as directed by my child’s licensed healthcare provider, in accordance with D.C Official Code § 38-651 and in emergency circumstances, in accordance with D.C Official Code § 38-656.

I understand:

- I am responsible for submitting school health forms including but not limited to: Medication and Medical Procedure Treatment Plan, Asthma Action Plan, Anaphylaxis Action Plan, Dietary Accommodation Form or other accepted school health form signed by my child’s medical provider to my child’s school if my child needs special medical care or medication. I am responsible for submitting an updated school health form annually for my child.
- I am responsible for bringing any needed medication or medical supplies listed on a complete school health form, in their original packaging, to the school nurse. All medication or medical supplies will be stored in a secured area of the school.
- I am responsible for collecting all expired medication kept at school within one week of its expiration date and within one week of the end of the school year. I understand that uncollected medication will be destroyed. Health suite personnel do not assume any responsibility for possible loss of medication or medical supplies.
- I am responsible for immediately notifying the school if any changes occur in the education and Medical Procedure Treatment Plan and providing all updated school health forms to the school. The health suite personnel can be reached by calling the health suite directly or by calling the school’s main phone number.
- I understand that the school or school health staff will not assume any responsibility for my child’s unauthorized self-medication or treatments. My child may only self-treat or self-administer medication for asthma, anaphylaxis or diabetes if they are approved to self-medicate as directed by a licensed medical provider and in line with a complete school health form.
- I hereby acknowledge and agree that, as provided for in D.C. Official Code sec. 38-651.11, the District, the school, its employees and agents (including school nursing staff) or the practicing physician, physician assistant or advanced practice nurse, who has issued a standing order shall be immune from civil liability for any acts or omissions relating to or arising from their good faith performance of responsibilities under D.C Official Code sec. 38-651.01 et seq., except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form must be completed and submitted before the student can receive health services.

**Student Name (printed)** \_\_\_\_\_ **Parent/Guardian Name (printed)** \_\_\_\_\_

**Parent/Guardian Signature/Student if age is 18 or older** \_\_\_\_\_ **Date** \_\_\_\_\_



## CONSENT TO SHARE STUDENT HEALTH EDUCATIONAL RECORDS

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. The purpose of this consent is to allow key school-based staff members (*such as the principal, school nurse, nurse case managers, 504 Coordinators and Special Education staff members*) who work with your child to share health-related educational records with external health-related agencies and healthcare providers, including school-based health centers (*if there is one located in your school*). These staff members and healthcare providers would then be able to better coordinate health-related services for your child. Coordinated health services will better ensure that your child's health needs are met, and that your child can fully participate in the school's learning environment. Please note that students may need additional support prescribed by a healthcare provider, or specified in an individualized education program (IEP) or a Section 504 Plan (a plan developed pursuant to Section 504 of the Rehabilitation Act of 1973 to provide additional accommodations or services to students with physical or mental health impairments); some of these services may not be provided by the school nurse or available in the school health suite. **IF YOU AGREE TO THIS CONSENT, PLEASE COMPLETE, SIGN AND RETURN IT TO THE REGISTRAR AT YOUR CHILD'S SCHOOL.**

_____	_____
(Student/Child's Name)	(School Name)
_____	_____
(Date of Birth)	
_____	_____
(Grade)	(Student ID, if known)

**1. I authorize the District of Columbia Public Schools to share the educational records regarding my child specified in**

**Section 3 below with each of the following agencies and organizations:**

- \*DC Department of Health,
- \*DC Department of Mental Health,
- \*DC Department of Health Care Finance,
- \*DC Department of Human Services,
- \*Your child's healthcare provider(s), and
- \*Other health service providers who deliver services in the school

**2. I understand that this information may be used ONLY for the following purposes:**

- \* Planning and providing coordinated educational and health related services, and
- \* Evaluating programs serving my child and the services provided to my child.

**3. I authorize the use/disclosure of each of the following records:**

- \*School nurse records,
- \* IFSP/IEP documents,
- \* 504 Plans,
- \* Class schedule,
- \*Attendance records,
- \*Behavioral Health Documents
- \* Grades, observations and other educational information contained in student records,
- \* Current Medication orders (retained by the school nurse),
- \* Eye medical reports,
- \*Audiology reports, and
- \*Nursing care plan (as part of IEP or 504 Plan)

**4. I understand that:**

- \* This authorization is voluntary and my child will not be refused educational services if I choose not to sign it, and;
- \* I have the right to request a copy of this form after I sign it and to see or copy any information disclosed under this consent.

**5. I consent to the use/disclosure of the above information. I understand that this information may not be used for any purposes other than those stated above in Section 2. This consent may be revoked in writing by me at any time. I understand that revoking this authorization will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.**

\_\_\_\_\_  
(Signature of parent/guardian/student over 18)

\_\_\_\_\_  
(Relationship to the student)

\_\_\_\_\_  
(Date)



## CONSENT TO SHARE STUDENT ATTENDANCE RECORDS WITH HEALTHCARE PROVIDERS

The Collaborative for Attendance Resources in Education and Health (CARE-H) project is a partnership between District of Columbia Public Schools (DCPS) and local medical providers for students who are enrolled at DCPS who are current Children’s National Hospital patients. The CARE-H project aims to support student health and reduce absenteeism, because students who are healthy are better able to attend school and learn. In order for the CARE-H project to work, DCPS schools must provide information on my child’s school attendance to my child’s primary healthcare providers.

By signing this consent, you give permission to DCPS to securely share attendance information with your child’s doctor(s), nurse(s) and medical office staff. This information will help these healthcare professionals provide special outreach and medical attention to students and their families, when needed. This will also allow DCPS to work with these healthcare professionals to keep my child healthy and successful at school.

I acknowledge and understand that I will have the opportunity to review the records and the right to challenge the contents of such records.

This authorization will continue through my child’s enrollment at DCPS, unless I withdraw my consent in writing. I can withdraw my consent at any time. NOTE: If DCPS wishes to share or discuss other parts of my child’s academic record with my child’s medical team, I will be asked to provide separate consent.

**Student Name (printed)** \_\_\_\_\_ **Parent/Guardian Name (printed)** \_\_\_\_\_

**Parent/Guardian Signature/Student if age is 18 or older** \_\_\_\_\_ **Date** \_\_\_\_\_

## SCHOOL HEALTH SERVICES TELEHEALTH PROGRAM TERMS AND CONDITIONS

The School Health Services Telehealth Program allows students to be seen remotely at their school by a medical care provider. By signing below, I understand, acknowledge and agree that:

- My child may participate in appointments conducted by video (videoconferencing) or phone call (teleconferencing) with healthcare providers such as behavioral health providers who may be at an off-school location. The healthcare provider may determine that an in-person follow-up visit or that urgent care or emergency services is required.
- In addition to my child’s healthcare team and provider, individuals who operate the video equipment and who are trained to maintain the confidentiality of all information obtained may also be present. The student has the right to request that: (1) specific details of their medical history/physical examination be omitted; (2) non-medical personnel leave the examination room; or (3) the visit be terminated at any time.
- I have the option to refuse a telehealth appointment for my child.
- I authorize the provider or its healthcare personnel to release any and all information to my child’s health insurance plan or any other agent that may be responsible for paying medical bills associated with the visit. I further authorize the School Health Services Telehealth Program to release specific medical information to school officials and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child’s health and safety.
- My insurance may be billed for Telehealth services. I understand I am responsible for providing insurance information and am responsible for any additional copay or charge resulting from this service. Enrollees in any DC Medicaid Managed Care Organization will not receive a bill for any of the services provided through telehealth. All charges associated with this program are at the discretion of the insurance company. Any copay that is required for primary care visits could apply for this service. I understand that any monies or benefits for providing telehealth will be assigned and transferred to the provider, including benefits/monies from my health plan, Medicaid, or other third parties who are financially responsible for my child’s medical care. I authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes.
- If I am not satisfied with the services rendered at any time, I may file a complaint with the Ombudsman team via phone: (202) 724-7491 or via email: [healthcareombudsman@dc.gov](mailto:healthcareombudsman@dc.gov). Complaints should also be submitted via the School Health Services Program portal at: <https://dchealth.force.com/studenthealthservices/s/>.
- This consent will be valid for the duration of the student’s enrollment in the school. I also understand that I have the right to withdraw my consent at any time by giving the health suite staff a signed and dated letter withdrawing my consent.

**Student Name (printed)** \_\_\_\_\_ **Parent/Guardian Name (printed)** \_\_\_\_\_

**Parent/Guardian Signature/Student if age is 18 or older** \_\_\_\_\_ **Date** \_\_\_\_\_