DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
Universal School-Based
Health Center Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Consent for Health Services and Treatment

Select School Student Attends:

❑ Anacostia SHS ❑ Ballou SHS ❑ Cardozo EC ❑ Coolidge SHS ❑ Dunbar SHS ❑ Woodson SHS ❑ Roosevelt SHS

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____-_____-_____

Sex: ❑ Male ❑ Female ❑ Other Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Student Address: _____
_____

Will the SBHC be the student's regular doctor? ❑ Yes ❑ No

If no, who is or will be the student's regular doctor?

Name: _____

Telephone: _____

Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, if applicable
Last Name: _____ First Name: _____

Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact information for parent or guardian

Home Tel: _____ Work Tel: _____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid coverage?

❑ No ❑ Yes: Medicaid ID #: _____

Which Plan?

❑ AmeriHealth Caritas DC
❑ MedStar Family Choice DC
❑ Health Services for Children with Special Health Care Needs (HSCSN)
❑ CareFirst Community Health Plan DC

Does your child have coverage through your employer or any other type of health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

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? ❑ Yes ❑ No

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the licensed health professionals at the School-Based Health Center as part of the school health program approved by the District of Columbia Department of Health (DC Health) and the District of Columbia Public Schools (DCPS) I understand that the school-based health center will ensure confidentiality in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. School health services, including screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Reproductive health care services, including abstinence counseling, providing access to birth control, pregnancy testing, STD screening and treatment, HIV testing, PAP smears when indicated, and referrals for abnormal results, as age appropriate.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
8. Dental treatment consisting of examinations, x-rays, diagnosis & treatment modalities that may include cleaning, administration of topical and local anesthesia, fillings, and sealants.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

PLEASE REVIEW AND SIGN BOTH SIGNATURE LINES ON PAGE 2

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MURIEL BOWSER, MAYOR

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature below authorizes release of health information obtained by the School Based Health Center to DC Public Schools and DC Health. This information may be protected from disclosure by federal privacy law and District law. I am further authorizing the School-Based Health Center to release specific medical information to DC Public Schools 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.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation. I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient, who shall provide written notification to the receiving party that this health information is being re-disclosed for the specific stated purpose, and that any additional re-disclosure will require additional consent.

I authorize the School-Based Health Center to release specific medical information of the student named on the reverse page to the DC Public Schools and DC Health.

I understand that the results of reportable diseases and immunizations administered will be released to DC Health and the DC Public Schools. In addition, case records and survey information may be used for program evaluation in accordance with Federal and District laws regarding patient confidentiality.

My signature in the Consent for Release of Health Information section of this form also gives my consent to the School-Based Health Center to contact other providers who have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed **To**: Date that student is no longer enrolled in the school

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

❑**YES:** I have read and understand the services listed on the previous page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the selected School-Based Health Center as long as my child is a student at the school. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In accordance with the Minor's Health Consent Regulation (22-B DCMR 600), parental consent is not required 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. Parental consent is not required for students who are 18 years or older or for legally emancipated students.
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, which shall include the practicing physician, physician assistant or advanced practice nurse, 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.

❑**NO:** I do not give permission for my child to receive SBHC services.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE REVIEW AND SIGN BOTH SIGNATURE LINES ON PAGE 2

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

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 health care providers would then be able to better coordinate health-related services for your child. Coordinated services will better ensure that your child's needs are met, and that he/she can fully participate in the school's learning environment. **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 health care 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,
* 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)

This authorization expires one year from the signature date above.