DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
School-Based Health Center

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Consent for Athletic Well-Child Exam Health Services and Treatment

SBHC Health Services Provider

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

DCPS School of Enrollment ______________________________

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: ______________________________
____

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: ______________

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

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia
School-Based Health Center

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

Consent for Athletic Well-Child Exam Health Services and Treatment

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 below 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 on opposite page **To**: Date that student is no longer enrolled in sports activities with DCPS

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 for well-child exam and sports clearance as long as my child is participating in DCPS sports activities. To promote continuity of care my child will only be enrolled at ONE SBHC. 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 page 2 of 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.

- ☐ **AUTHORIZATION/ CONSENT FOR CARE AND SERVICES:** I authorize Mary's Center to provide all medical care, treatment, and services recommend or deemed necessary for examination, diagnosis and treatment of my health care concerns which includes but is not limited to: Health, Dental, Behavioral Health, Education or Social Services. I understand that family planning services are voluntary and do not require one to receive any other services offered by Mary's Center.
- ☐ **CONSENT FOR TREATMENT OF MINORS:** Mary's Center requires that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments or plan of care which may include but is not limited to receiving laboratory services, examination, vaccination, minor medical surgical procedure, as well as social services support or education. (except for limited circumstances where a minor is legally able to provide consent under applicable law). In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this Consent for Treatment of Minors. I authorize care and treatment for my unaccompanied minor child referenced as Patient's Printed Name below. I agree to be financially responsible for the services rendered to my minor child by Mary's Center in my absence. Contraceptive and sexual health services to minors **DO NOT REQUIRE** the consent of a parent/guardian.

ALTERNATIVE REPRESENTATIVE: The following individuals are above the age of 18 and may authorize treatment on behalf of the patient listed below. I fully consent to all services rendered including but not limited to lab work, immunizations, developmental, screenings and other services as deemed necessary per the Providers recommendations. I give permission for Mary's Center staff to verbally discuss all, scheduling, appointment information, medical information, including but not limited to my symptoms, diagnosis, medications, treatment plans, lab/test results, billing, payment, or other information pertaining to my treatment or care.

Name	Phone	Relationship to Patient

- ☐ **TELEHEALTH SERVICES:** Allows Mary's Center team members to provide you with safe and effective care. *Services include but are not limited to telemedicine, telemedicine facilitated by a home visitor, teletherapy, teledental, etc.* Risks include poor audio or visual connection and lack of privacy, as well as the need to seek care in person if an assessment cannot be completed virtually. Mary's Center will follow standardized practices to protect the privacy and security of your personal health information and will do our best to meet your needs online.

By checking this box, I agree Interaction with the clinical team will be virtual, through audio or visual connection, unless I agree to a facilitated telemedicine visit which involves a visitor in my home. I understand that there are limits to telehealth and that some diagnoses/treatments may require an in-clinic visit to complete the assessment. My care team will help me determine when I should come to the clinic and when it is safe for me to receive care virtually. I have been advised of the risks and benefits of telehealth as explained above and understand the laws that protect the privacy and confidentiality of medical information also apply to telehealth. I know I can ask the care team if I have concerns or questions about telehealth at any time. I understand that I have the right to withhold or withdraw my permission to the use of telehealth during my care at any time, without affecting my right to future care or treatment at Mary's Center. I may revoke my decision orally, or in writing at any time, by contacting Mary's Center.

PATIENT PORTAL: Mary's Center would like to introduce the Patient Portal to all patients. The Patient Portal is an easy and comfortable way to learn all you need about your health when you visit your medical provider. With just one click you will have access to medical results, upcoming appointments, messages from your doctor, visit summaries and more all without leaving your home.

☐ **By checking this box, you express you interest in enrolling in the following email address into the Patient Portal:**
Parent email address: ____________________
Minor Patient email address: ____________________

☐ Does not have email.

☐ Does not want to enroll.

Health Information Exchange (HIE)

Mary's Center is a participant in the Health Information Exchange (HIE) plan. The HIE stores patient medical information that is exchanged through a network of participating hospitals and clinics. HIE participants may use and disclose medical information about you with other participants for treatment (including the review of your prescription history to prevent adverse drug interactions and overdose), payment and health care operations, consistent with HIPAA requirements and the HIE policies, including medical information collected by Mary's Center.

☐ Check here **only if you request to opt-out**, withhold or withdraw your health information from the Health Information Exchange (HIE) plan. This will withdraw your permission to share or view health information with any participating HIE provider from this day forward. I understand that information recorded by my clinician and maintained in the clinician's own electronic health records cannot be removed as this constitutes the clinician's medical record. If you have chosen to Opt-Out, please inform the front desk receptionist to obtain the necessary form.

HIPAA STATEMENT/ PRIVACY NOTICE

Mary's Center for Maternal and Child Care, Inc. is committed to respecting the privacy of our patients and maintaining the confidentiality of their protected health information. When you consent to treatment at this organization, you consent to the use of your information as outlined in the "Notice of Privacy Practices" which as been provided to you and is posted on our company website and offices. If you have questions regarding your participation in the HIE or have any questions or comments regarding our Privacy Policies or the security of your information, please feel free to contact t our Chief Compliance /Privacy Officer, Lisa Norris, at (202)975-2172.

This authorization expires: ϒ When I cancel it in writing (or on) ϒ __________ (specify date)
If no expiration date is specified, this authorization will remain in effect until Mary's Center receives written notice to cancel.

Patient's Printed Name: ____________________ DOB: __________

Signature of Patient/Patient Representative: ____________________

If signed by Patient Representative, specify relationship the patient: ____________________

Guidelines for 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?
   ☐ Yes ☐ 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?
   ☐ Yes ☐ 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?
   ☐ Yes ☐ No If yes, please explain. ____________

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ 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
ADHD/learning disability	☐	☐	______
Allergies/hayfever	☐	☐	______
Asthma	☐	☐	______
Bladder or kidney infections	☐	☐	______
Blood disorders/sickle cell anemia	☐	☐	______
Cancer	☐	☐	______
Chicken pox	☐	☐	______
Depression	☐	☐	______
Diabetes	☐	☐	______
Eating disorder	☐	☐	______
Emotional disorder	☐	☐	______
Hepatitis (liver disease)	☐	☐	______
Headaches/migraines	☐	☐	______
Low iron in blood (anemia)	☐	☐	______
Pneumonia	☐	☐	______
Rheumatic fever or heart disease	☐	☐	______
Scoliosis (curved spine)	☐	☐	______
Seizures/epilepsy	☐	☐	______
Severe acne	☐	☐	______
Stomach problems	☐	☐	______
Tuberculosis (TB)/lung disease	☐	☐	______
Mononucleosis (mono)	☐	☐	______
Other: ____________	☐	☐	______

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ 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	☐	☐	☐	________	____________
Arthritis	☐	☐	☐	________	____________
Birth defects	☐	☐	☐	________	____________
Blood disorders/sickle cell anemia	☐	☐	☐	________	____________

© 1997 American Medical Association all rights reserved

AA59:97-894:11/97

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type__________________)	☐	☐	☐	__________	__________
Depression	☐	☐	☐	__________	__________
Diabetes	☐	☐	☐	__________	__________
Drinking problem/alcoholism	☐	☐	☐	__________	__________
Drug addiction	☐	☐	☐	__________	__________
Endocrine/gland disease	☐	☐	☐	__________	__________
Heart attack or stroke *before* age 55	☐	☐	☐	__________	__________
Heart attack or stroke *after* age 55	☐	☐	☐	__________	__________
High blood pressure	☐	☐	☐	__________	__________
High cholesterol	☐	☐	☐	__________	__________
Kidney disease	☐	☐	☐	__________	__________
Learning disability	☐	☐	☐	__________	__________
Liver disease	☐	☐	☐	__________	__________
Mental health	☐	☐	☐	__________	__________
Mental retardation	☐	☐	☐	__________	__________
Migraine headaches	☐	☐	☐	__________	__________
Obesity	☐	☐	☐	__________	__________
Seiures/epilepsy	☐	☐	☐	__________	__________
Smoking	☐	☐	☐	__________	__________
Tuberculosis/lung disease	☐	☐	☐	__________	__________

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

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

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

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

Parental/Guardian Concerns

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

	Concern About My Adolescent
Physical problems	☐
Physical development	☐
Weight	☐
Change of appetite	☐
Sleep patterns	☐
Diet/nutrition	☐
Amount of physical activity	☐
Emotional development	☐
Relationships with parents and family	☐
Choice of friends	☐
Self image or self worth	☐
Excessive moodiness or rebellion	☐
Depression	☐
Lying, stealing, or vandalism	☐
Violence/gangs	☐

	Concern About My Adolescent
Guns/weapons	☐
School grades/absences/dropout	☐
Smoking cigarettes/chewing tobacco	☐
Drug use	☐
Alcohol use	☐
Dating/parties	☐
Sexual behavior	☐
Unprotected sex	☐
HIV/AIDS	☐
Sexual transmitted diseases (STDs)	☐
Pregnancy	☐
Sexual identity (heterosexual/homosexual/bisexual)	☐
Work or job	☐
Other: ______________________	☐

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? ☐ Yes ☐ No

© 1997 American Medical Association all rights reserved