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

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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.

GENERAL CONSENT FOR PROCEDURES AND TREATMENT

I understand that Children's National Medical Center (Children's National) needs me to sign a consent. I understand I need to sign it before my child or myself as a patient 18 years of age and older can be examined or treated. I give consent to Children's National and its employees and/or contractors to examine and treat this patient by signing this paper.

I, _____ give consent to Children's National, its employees

and/or contractors to examine and treat_____.

I understand that:

- Tests and immunizations may be included;
- I may need to give a separate written consent for some treatments and procedures;
- **I can cancel this Consent in writing and/or limit release of medical records. If I notify Children's National in writing to cancel this Consent, Children's National may no longer examine and treat the patient**
- There are no guarantees for outcomes and results.

TEACHING, TRAINING AND EDUCATION

I understand that Children's National teaches and trains students in health care careers. I understand that physician teachers on Children's National's medical staff direct all student care at Children's National.

EDUCATION, PUBLICATIONS, MARKETING AND FUNDRAISING

I agree that Children's National may use unidentifiable patient medical information, statements, artwork, videos or pictures. As long as the patient cannot be identified, these items may be used for teaching purposes, educational/medical publications, marketing and fundraising. If identifiable information or a patient's likeness is used in any public capacity, Children's National will seek additional authorization from the patient's guardian.

PATIENT RIGHTS (parent or adult patient to check mark below)

☐ I have been given information about Patient Rights and the Notice of Patient Privacy Practices at Children's National in a language that I understand. I know who to contact with questions or concerns or to file a complaint.

ADVANCE DIRECTIVES: An advance directive, also known as a living will, is a legal document in which an adult patient specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. Booklets are available to patients over 18 years of age.

☐ Please check if one is needed and request a copy from the registrar or clinical staff.

☐ I have an advance directive and have been asked to provide a copy.

☐ Not applicable – patient is under 18 years of age

SPECIMENS AND BLOOD TESTING

I understand that some blood, tissues and other samples taken for tests or procedures may be left over after the test or procedure is finished. I agree that these items may be used for teaching, research or in medical chart review if the patient cannot be identified. These uses must first be approved by an Institutional Review Board and are not covered by U.S. law on human research. I understand that a health care provider may accidentally come into contact with the patient's blood or body fluids. If this happens, I consent to testing the patient for infectious diseases including HIV. I agree that the exposed person may be given the results. I understand that the law may require Children's National to report some medical outcomes to the government.

OBSERVATION AND MONITORING

I understand that Children's National may use video or other recording devices for treatment, teaching, monitoring of the condition, progress, and safety of the patient, or other clinical purposes including quality improvement related to Children's National's services. Photographs created for these purposes will not identify the patient by name. This does not include photographs for publicity which involve signature of a separate consent and release form.

PARENTAL ACCESS TO INFORMATION, VISITATION, DISCLOSURE (For Patients Under 18 Years Old)

I understand that either parent may see the medical record, visit the patient, take the patient home, or make care decisions. If a court has limited either parent's rights, I agree to give Children's the court paper stating so. I agree to give Children's National the names of any other people who I want to get information about my child. I agree to tell Children's National how to reach me such as by phone, cell phone, fax, mail, or e-mail. By providing Children's National with my cell phone and or landline phone, I agree to be contacted via text message, voice and/or recorded call by Children's National or its contracted business associates for all healthcare calls to include: appointment reminders, pre-registration instructions, prescription notifications, accounting, billing, or debt collection.

I understand that Children's National follows all federal and local laws including the Health Insurance Portability and Accountability Act. I understand that this Consent allows Children's National to use private health information for treatment, payment and hospital operations as defined in the Notice of Privacy Practices. I agree that Children's National may use de-identified health information about my child for approved research and quality improvement activities.

I understand that if my child is enrolled in my local public or private school system, limited information about my child's admission may be shared with the local school nurse in order to ensure continuity of care after my child's discharge.

The Children's IQ Network® connects Children's National hospital, emergency department, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories. Health data pertaining to you or your child is shared between authorized

health care providers within the Children's IQ Network® to ensure that accurate and complete information is available to make your care or the care of your child safer, more efficient, and less costly.

☐ I hereby request to not have my or my child's healthcare information shared with other health care providers within the Children's IQ Network

PAYMENT, INSURANCE, AND ASSIGNMENT OF BENEFITS AUTHORIZATION

I assign to Children's National the right to bill and collect from any insurance that covers the patient. I agree to help Children's National seek payment and to tell the Children's National about any resources for payment of the patient's bill. I will pay any deductible, co-payment, and any amounts denied or not covered by insurance. If the patient is uninsured, I will apply for medical assistance programs including but not limited to Medicaid. If the patient is uninsured and is not eligible for a medical assistance program I agree to give financial information to Children's National to see if I am eligible for reduced charges or charity funds.

I understand that there may be professional fees associated with the patient's care and that those fees will be billed separately by the persons or organizations that provided the services. I assign the right to bill and collect from any insurance that covers the patient to any physicians, caregivers, or other providers of services who are not employed by Children's National and whose services will be billed separately for all treatment provided.

I consent to use and disclosure by Children's National and/or the patient's care providers of portions of the patient's Record, including medical records (including **psychiatric, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, which may include HIV or AIDS diagnosis), to any person or entity that is or may be responsible for all or any portion of Children's National's and/or providers' charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organizations of the foregoing** or to any other person or entity as necessary in connection with such payments or reimbursement.

I also agree that Children's National and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record information (including medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information) to treating Children's national personnel and agents, other health care providers, medical records auditors, professional care committees, evaluators and governmental agencies in order to treat the patient or for Children's National to carry out its operational duties.

SPECIAL BILLING CIRCUMSTANCES

I understand that I must read and check mark (√) any of the below statements that apply to special billing circumstances. I understand and agree that I am personally responsible for making full payment for all charges resulting from this Consent for Services.

☐ Requested services that are outside of my insurance company's network.

☐ Knowingly requested services outside my highest level benefit option (e.g., Preferred, POS Choice, Select, etc...) and that my 'out of pocket' financial responsibility may be greater as a result.

☐ Not provided Children's National with the proper referral form, referral information and/or authorization.

☐ Not provided Children's National with adequate proof of insurance.

☐ Voluntarily requested that Children's National NOT bill any insurance I may have, without regard to whether these services are covered by any such insurance.

PATIENT IDENTITY

My signature below means that I have given truthful information about the patient's name and identity. It also means that I understand:

- How important it is to provide truthful and accurate information about the patient's name and identity.
- That incorrect or false information about identity can lead to treatment that could be harmful to the patient
- That Children's National reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

DISCHARGE

I understand that Children's National is an acute care facility and that once the patient is medically able, he/she will be discharged to home or to a non-acute care facility. I consent to a transfer or discharge once the attending physician determines that it is medically appropriate. If I do not take the patient home after the patient is discharged to home, I agree to pay Children's National's full inpatient charges for additional days and services. I will provide the specific names of any persons other than the parents/legal guardian who are authorized to take the patient home when discharged from inpatient or outpatient care.

SIGNATURES

_____ Date/Time:_____
Signature of Parent/Legal Guardian/Patient 18 years of age or older.

_____ _____ _____
Print Name Relationship to Patient Phone Number

_____ Date/Time:_____
Signature of Children's National Employee (witness)

THE PATIENT MAY BE DISCHARGED TO:

_____ _____ _____ _____
Name (please print) Relationship to Patient Phone Number Parent's Initials

_____ _____ _____ _____
Name (please print) Relationship to Patient Phone Number Parent's Initials

THE PATIENT WAS DISCHARGED TO:

_____ Date: _____ Time: _____
Signature of Person Picking Up the Patient

_____ _____ _____
Print Name Relationship to Patient Phone Number

EMERGENCY CONSENT:
This patient needs immediate attention. Efforts are being made to locate the parent or legal guardian. A delay in admission and treatment will be harmful.

_____ Date: _____ Time: _____
Physician Signature

_____ Date: _____ Time: _____
Physician Signature

Revised as of 5/2016