NEW HAVEN PUBLIC SCHOOLS
SCHOOL HEALTH CENTER PERMISSION FORM

New Haven Public Schools operates 17 school health centers (SHC) located in K-8 and high schools. All students enrolled in their school's SHC are eligible to receive services. The SHC providers do not replace your child's regular health/mental health providers. NHPS works with community health partners to staff the SHCs during the school day so that students and parents need not miss school or work unnecessarily, and the SHC staff consult with your regular providers when needed. Our community partners include: Yale-New Haven Hospital, Fair Haven Community Health Center, Cornell Scott Hill Health Center, New Haven Health Department, and Clifford Beers Guidance Clinic. All services are free to students (no cost/fees to families), though billable services may be submitted directly to your insurance companies. All students under age 18 must have a parent permission form completed/signed by a parent/guardian to receive services in a SHC.

SHCs are staffed by a team of licensed professionals that usually include a medical provider (nurse practitioner or physician assistant), a social worker and an office manager/clerk. The medical provider offers preventive medical services like immunizations and physical exams, acute care such as diagnosing, treatment and follow-up of illnesses and injuries, and management of chronic conditions like Asthma and Diabetes. The social worker provides assessment, individual/group/family counseling, student support groups, crisis intervention, and short/long term therapy as needed. All SHC providers work closely with the family, community providers, and with the school nurse and school staff to ensure that students get the care they need at school, or through community support services. To enroll your child/ren in the SHC, please complete and sign one permission form for each child at this school, and be sure all information on the front and back of this permission form is complete.

School:_____ **Date:**_____ **Grade:** ____ **HRM Teacher:**_____

Child's name: _____ **Sex:** ___ Female ___ Male

Address: _____ City: _____ Zip Code: _____

Student ID _____

Child's Ethnicity/Race:
___Hispanic/Latino ___Not Hispanic/Latino

Race:
___ Black or African American ___ White ___ Asian Other_____
___ American Indian or Alaskan Native ___ Native Hawaiian/Other Pacific Islander ___ Unknown

Religion(optional)_____

Child's Social Security #: _____ **Birth Date:** ____/____/_____

Mother/Father or Guardian Name:_____
Primary Home Address: _____
Home Phone: _____ Work Phone: _____ Cell: _____

Parents: __Married __Divorced ___Separated ___ Mother Deceased ___Father Deceased __ Single

Who lives with Student: *(check all that apply)*
___ Mother ___ Father ___ Step Mother ___ Step Father ___ Sisters ___ Brothers ___ Other _____

Emergency contact (*Please provide the names of two adults to notify in an emergency, if you are not available)*:
Contact Name: _____ Phone # _____ Relationship _____
Contact Name: _____ Phone # _____ Relationship _____

Preferred Language: _____
Parent: _____ **Need Interpreter?** ___Yes ___No

Type of Insurance (check all that apply and complete information below on your child's insurance coverage)
___ **Medicaid** ___ **Husky A** ___ **Husky B** ___ **Private/Commercial Insurance** ___ **Dental** ___ **No Insurance**

MEDICAID OR HUSKY INSURANCE:
Insurance ID #: _____ Name of Managed Care Health Plan: _____

PRIVATE/COMMERCIAL INSURANCE:
Policy Holder's Name: _____ Relationship to Student: _____
Date of Birth: _____ SS# _____
Policy Holder's Address: _____ Policy #: _____
Insurance Carrier Name and Address: _____
Employer Name _____ **Occupation:** _____
Employer address: _____ **City**_____ **State**_____ **Zip**_____

Where do you usually get your child's medical care?

___ Community Health Center
___ Emergency Room
___ Health Department Clinic
___ Hospital Clinic
___ Military Clinic
___ NoRegular Source
___ Other Type
___ Private Doctor
___ School Based Health Center
___ Unknown
___ Walk-in-Clinic

Name of child's Primary Health Provider: _____ **Phone:** _____ **Date of last Physical Exam:** _____

Name of Child's Dentist: _____ **Phone:** _____ **Date of last Dental Exam:** _____

Preferred Pharmacy: Name/Address: _____ **Phone:** _____

NEW HAVEN PUBLIC SCHOOLS - SCHOOL HEALTH CENTERS

Clinton Avenue	(203) 691-3318	Fair Haven	(203) 691-2643	Hillhouse	(203) 497-7555
Brennan-Rogers	(203) 946-2934	King-Robinson	(203) 691-2791	Wilbur Cross	(203) 497-7444
Lincoln-Bassett	(203) 492-8516	Roberto Clemente	(203) 497-7617	Career	(203) 946-2262
Davis Street	(203) 497-7815	Mauro-Sheridan	(203) 691-2815	Hill Central	(203) 499-6119
Truman	(203) 691-2122	Troup	(203) 691-3076	Barnard	(203) 691-3584
Riverside Academy	(203) 946-7184				

SCHOOL HEALTH CENTER SERVICES AVAILABLE TO STUDENTS:

Ages 3-18:
School Physical Exams
Treatment of Asthma, Anemia, Acne and Other Health Problems
Nutrition and Weight Counseling
Referral for Specialty Care
Immunizations
Mental Health Individual and Group Counseling
Diagnosis and Treatment of Minor Illness/Injuries
Issue-oriented Support Groups
Substance Abuse Education/Counseling
Crisis Intervention

Ages 12-18:
HIV/AIDS/STD Education, Counseling and Testing
HIV/STD Prevention (including condom availability)
Pregnancy Testing
Reproductive Health
Contraceptive services available to female students

DOES YOUR CHILD HAVE A HISTORY OF ONE OF THE FOLLOWING (Please circle YES or NO):

	YES	NO	IF YES, PLEASE EXPLAIN:
1.	Y	N	Allergy to food or medicine _____
2.	Y	N	Taking medication regularly _____
3.	Y	N	Chronic health problem such as: asthma, diabetes, TB, heart disease, vision, hearing, dental or speech problem. _____
4.	Y	N	Hospitalization, surgery or major illness _____
5.	Y	N	Significant injury or accident _____
6.	Y	N	Has your child ever been referred for counseling? _____
7.	Y	N	Does your child have any emotional, social or behavioral problems? _____
8.	Y	N	Does your child have school attendance problems? _____
9.	Y	N	Has your child experienced major stress event in past year such as a move, loss of or illness of loved one, bullying, violence? _____

I have read the materials supplied to me regarding the services of the School Health Center and I give permission to the above named student to use the services provided by the School Health Center for as long as she/he is enrolled in the New Haven Public Schools. I do ***not***, want my child/ward to receive the following services from the School Health Center:

1._____ 2. _____ 3. _____

As the parent/guardian of the student identified above, I understand that I may revoke the permission at any time for any reason and that I may add to or subtract from the services I do not want my child/ward to receive by informing the School Health Center staff in *writing* that I wish to withdraw or change my permission/instructions. I give the SHC staff permission to communicate with key school personnel if needed, to facilitate quality case management. Furthermore, I give permission to the School Health Centers to release information regarding treatment and/or services to the above insurance providers for the purpose of billing. I authorize payments to be made directly to the agency providing services or New Haven Public Schools. I also acknowledge receipt of the SBHC Privacy Notice.

_____ _____

Signature (Parent/Guardian) **Date**

NEW HAVEN SCHOOL-BASED HEALTH CENTERS

PRIVACY NOTICE

According to federal law, we are giving you this Notice of Privacy Practices. It describes how we may use and share your child's protected health information (PHI). If you are 18 years old or older or an emancipated minor, ' your child' refers to you. It also describes your rights to access your child's PHI. "Protected Health Information" (PHI) is information about your child, including demographic information that may identify your child and that, in any way, relates to your child's physical or mental health

PLEASE READ THIS NOTICE CAREFULLY.

New Haven School-Based Health Centers (SBHCs) are committed to respecting your and your child's privacy. Therefore, we are required to abide by the terms of this Privacy Notice. We may change the terms of this notice at any time. Updates/revisions will be posted in your child's health care provider's office. Copies will be available upon your request.

How We Will Use and Disclose Your Child's PHI With Your Signed SBHC Consent

Once you sign the SBHC Permission Form, we will provide direct medical/mental health care to your child, even if you are not present at the time we see your child for services. After the permission form is signed, we may share your child's PHI in order to carry out treatment, payment and/or healthcare operations. Here are some specific examples of how we will share your child's PHI.

Treatment: In order to ensure the highest quality of service for your child, we will use and share your child's PHI to provide, coordinate or manage your child's medical/mental health care. We will share only information that is necessary for your child's health and welfare. We may share PHI with other providers/clinics that contribute medical/mental health care to your child located within or outside the school. Examples of providers include but are not limited to: school nurse, nurse practitioners, medical doctors, social workers, dentists, professional counselors, outreach workers and medical assistants. Furthermore, the SBHC may need to exchange information with a representative(s) of the New Haven Public Schools. We may also use and share your child's PHI with a member of your family, a relative, a close friend or any other person you identify on your child's SBHC Permission Form. This will include notifying people identified as an emergency contact on your child's consent form. In addition, during a parent guidance or family counseling session, we may disclose your child's PHI to you and those present.

Payment: Your child's PHI will be used and shared to obtain payment for health care services if you have insurance. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services. In addition, we may use and share your child's PHI to help you and/or your family to obtain medical insurance (such as HUSKY) and services from other social service agencies.

Healthcare Operations: In order to ensure the highest quality of service possible to your child, we may use and share your child's PHI in order to support the business activities of the clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, supervision of employees, training of students, and licensing. We will send a pass to your child's teacher for your child to come to the clinic for an appointment. We may call your child by name over the school's intercom system to come to the clinic. We may telephone you to remind you of your child's appointment. Furthermore, we will share your child's PHI with third party "business associates" necessary to perform various activities for the clinic. Whenever an arrangement between our office and a business associate involves using or sharing your child's PHI, we will have a written contract that contains terms that will protect the privacy of your child's PHI. Only relevant information that is necessary for the business associate to perform its duties will be shared.

The above examples are not inclusive of all the activities related to payment, operations and treatment. Other activities NOT related to payment, treatment, and operations will require that you give us **written authorization**, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time.

Other Ways We May Use or Disclose Your Child's PHI With Your Written Authorization Or Opportunity to Object

We may use and share your child's PHI with your written authorization or opportunity to object in the following instances. If you are not present or able to agree or object to the use of the PHI, then your child's provider may, using professional judgment, determine whether the disclosure is in your child's best interest. In this case, only the minimal necessary PHI that is relevant to your child's health care will be disclosed.

Communication Barriers: We may use and share your child's PHI if a provider or other staff member in the clinic attempts to obtain consent from you but is unable to do so due to substantial communication barriers. If the provider determines, using professional judgment, that you intend to consent to the use of your child's PHI, the provider will do so. In order to serve you better, we may engage the aid of interpreters when a language barrier exists.

Potentially Harmful Activity: You may request, in writing, that a SBHC site will not release yours or your child's PHI to a particular individual/agency if you believe such a disclosure may result in potential harm to you or your family's safety.

Outside Referrals: We will require a written authorization to release your child's PHI to a third party i.e.: community medical/mental health provider or an agency in which there has been no previous or current relationship.

Emergency Treatment: We may use or share your child's PHI in an emergency treatment situation. We will try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your provider or another health care provider in the clinic is required by law to treat your child and the provider is unable to obtain your consent, he or she may use or share your child's PHI in order to provide a high quality of emergency care.

How We Will Use or Disclose PHI Without Your Consent, Without Written Authorization Or Without Opportunity to Object

The following are examples of other ways we may use and share your child's PHI without your consent, written authorization or opportunity to object. These are some examples in which we are required by law to share your child's PHI.

Required by Law: We may use or share your child's PHI if the law requires it. The use of your child's PHI will be made in compliance with the law and will be limited to relevant requirements of the law. You will be notified, as required by law, if we use and share your child's PHI in this way.

Public Health: We may share your child's PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Communicable Diseases: We may share your child's PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may share your child's PHI with a health oversight agency for activities authorized by law, such as audits, investigations and inspections.

Abuse or Neglect: We may share your child's PHI with a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we suspect that your child may have been a victim of abuse, neglect or domestic violence we may share your child's PHI with the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may share your child's PHI with a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements or to conduct post marketing surveillance as required.

Legal Proceedings: We may share your child's PHI in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena; discovery request or other lawful process.

Law Enforcement: We may also share your child's PHI for law enforcement purposes.

Research: We may share your child's PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of the PHI.

Harmful or Self-Harmful Activity: Consistent with applicable federal and state laws, we may share your child's PHI, if we suspect that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of your child or another person or the public. For example, if your child threatens to hurt himself or herself or someone else, to commit suicide or homicide, or damage someone's property, we may disclose his/her PHI to the appropriate parties, including New Haven Board of Education authorities.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS

The following is a statement of your rights with respect to your child's PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your child's PHI, as per our protocol, which is contained in a designated record set for as long as we maintain the record. If your child is 18 years or older or an emancipated minor, he/she is considered an adult and you (the parent or guardian) do not have the right to inspect and/or copy their record.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law and prohibits access to PHI of minors especially with respect to reproductive health, sexually transmitted infections, and drug or alcohol abuse/treatment.

You need to place this request in writing and the SBHC has 30 days to respond to this request, unless the PHI is not located on the site, then SBHC has 60 days to respond. The SBHC may ask for one extension of 30 days, and will provide you with a written statement of reasons for the delay and date of completion.

The SBHC has the right to deny a request if it is deemed the release of this PHI will likely endanger the life or safety of the individual or indirectly harm others mentioned in this PHI. The SBHC will provide a written statement of any denials.

You have the right to request a restriction on uses/disclosures of your child's PHI. This means you may ask us not to use or disclose any part of your child's PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your child's PHI not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in this Privacy Notice. Your request must be in writing and state the specific restriction requested, to whom you want the restriction to apply, and the time frame of the restriction. You may withdraw a restriction for disclosure in writing at any time.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your child's best interest to permit use and disclosure of their PHI, your child's PHI will not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your child's PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your provider or clinic staff.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. Please make this request in writing to our Privacy Officer or clinic staff.

You may have the right to have your provider amend your child's PHI. This means you may request, in writing, an amendment of PHI about your child in a designated record set for as long as we maintain this information. The SBHC has to respond to this request within 60 days. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your child's medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your child's PHI. This right applies to disclosures for purposes **other than** treatment, payment, or healthcare operations as described in this Privacy Notice. It excludes disclosures we may have made to you, for a facility directory, to a family member or friends involved in your child's care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 and for the next six years. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions, and limitations outlined in SBHC's policy and procedure guidelines. Please contact the SBHC Privacy Officer for further details.

ALL SERVICES ARE AVAILABLE TO ENROLLED STUDENTS REGARDLESS OF THEIR ABILITY TO PAY OR INSURANCE COVER

QUESTIONS OR COMPLAINTS

You may file a complaint to our Privacy Officer or the Secretary of Health and Human Services if you believe the privacy rights of your child have been violated. We will not retaliate against you or your child for filing a complaint. Please contact your child's SHC site or the Privacy Officer at (203) 946-4860 if you have any questions regarding this Privacy Notice.