DELHI COMMUNITY HEALTH CENTER
SCHOOL-BASED HEALTH CENTER ENROLLMENT PACKET
2021-2022

STUDENT NAME: _____ DOB: _____ GRADE: _____

When applicable, I (parent/guardian) request the following course of action for the above mentioned student with regard to care provided at Delhi Community Health Center (DCHC) School Based Health Center.

YES	NO	Medical Treatment and Medication Administration Preferences
		You **may provide** a medical screening exam and treatment if my child presents to the clinic for evaluation.
		You **may schedule** my child for routine wellness exams and sports physicals.
		You **may administer** any of the available **Over the Counter Medications** to my child. (List Attached)
		You **may administer** CDC recommended immunizations to my child if they **are eligible****. (A current Immunization Schedule will be provided if your child needs immunizations.)

****Vaccines at the SBHC are provided by Vaccines for Children (VFC). Children are eligible to receive VFC vaccines if they meet certain criteria.**

Eligibility criteria can be found at: https://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html

PUBLIC NOTICE: THE SCHOOL BASED HEALTH CENTER AT DELHI MIDDLE SCHOOL IS UNABLE TO PROVIDE ONSITE VACCINATIONS. PATIENTS THAT UTILIZE THE SCHOOL BASED HEALTH CENTER AT DELHI MIDDLE SCHOOL WILL NEED TO SCHEDULE AN APPOINTMENT AT DELHI COMMUNITY HEALTH CENTER (318-878-6162) OR WITH THEIR PRIMARY CARE PROVIDER TO RECEIVE THEIR REQUIRED VACCINATIONS.

Print Name (Parent/Legal Guardian) _____ Relationship: _____

Signature (Parent/Legal Guardian) _____ Date: _____

DELHI COMMUNITY HEALTH CENTER

SCHOOL-BASED HEALTH CENTER ENROLLMENT PACKET

2021-2022

Student's Name: Last First Middle Initial				ID# (Office use only.)
Student's Address:				Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Ethnicity: ❑ Hispanic or Latino ❑Not Hispanic or Latino	
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ More than one race				
Student's Social Security Number:	❑ Delhi Elementary School ❑ Delhi High School ❑ Delhi Middle School ❑ Delhi Charter School			Student's Grade:
Preferred Language:	Student/Parent Email:		Student's Cell Phone: ( )	
Name of Mother/ Legal Guardian: (include maiden name)	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Emergency Contact:			Relationship:	Phone: ( )
Emergency Contact:			Relationship:	Phone: ( )
Student's Primary Care Physician: ❑ Please check if student does not have a Primary Care Provider				Phone: ( )
Student's Dentist: ❑ Please check if student does not have a Primary Dentist		Student's Eye Doctor (optometrist/ophthalmologist):		
Preferred Pharmacy:	Names of siblings enrolled in School-Based Health Center:			

Please check the type of health insurance your child has: **Please send a copy of insurance card (front and back) to SBHC.**	❑ Medicaid/Healthy Louisiana #: _____ (check one below) ❑ Aetna Better Health ❑ AmeriGroup Real Solutions ❑ AmeriHealth Caritas LA ❑ LA Healthcare Connections ❑ United Healthcare Community Plan ❑ Medicaid (dental) #: _____ ❑ No insurance ❑ Private/Other Insurance Co. Name:_____ Co. Address:_____ Phone #:_____ Policy #:_____ Group#:_____ Effective Date:_____ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder Social Security #:_____ Does your insurance pay for prescriptions? ❒ No ❒ Yes

If your child does not have insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

Is your child allergic to any food or medicine? ❒ No ❒ Yes If yes, list:

List of current medications/vitamins/supplements student is on with dosage (how much) and how often:

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness/injury including medications ♦management of chronic diseases ♦behavioral health services♦health education and prevention programs ♦case management♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services

STUDENT NAME: _____ DOB: _____ GRADE: _____

Student Medical History

(Please indicate which medical conditions your child has been treated for or have concerns your child might have)

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies (seasonal)			Speech Problems
		Asthma (Please bring inhaler to clinic)			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor Appetite			Other:

Student Surgical & Hospitalization History

Has your child ever had surgery? *(If yes, please specify below)* ❑ Yes ❑ No

Y	N	Surgery	Y	N	Surgery
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Has your child ever been admitted into a hospital? *(If yes, please specify below)* ❑ Yes ❑ No

Hospital	Date	Reason

Family Medical History

(Which of the following medical conditions apply to you or an immediate family member)

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Behavioral Health Concerns				Tuberculosis	
		Nervous/Mental Disorder				Other:	

Reviewed by: _____ Follow-up planned by: _____

STUDENT NAME: _____ DOB: _____ GRADE: _____

Student Environmental/Housing History

ESTIMATED ANNUAL HOUSEHOLD INCOME	PLEASE ANSWER THE FOLLOWING:		WHICH OF THE FOLLOWING BEST DESCRIBES YOU CURRENT LIVING SITUATION?
❒ $10,000 – $20,000 ❒ $21,000 – $35,000 ❒ $36,000 – $40,000 ❒ $41,000 – $50,000 ❒ $51,000 +	**Water Supply**	❑ CITY ❑ WELL ❑ NONE	***My child and I currently live in…*** ❑ our own home ❑ someone else's home with another family ❑ various homes with other families ❑ a transitional home/halfway house ❑ a shelter ❑ car on the street
	Sewer	❑ CITY ❑ WELL ❑ NONE	
	Pets in Home	❑ YES ❑ NO	
	Smokers	❑ YES ❑ NO	

PLEASE LIST ALL PEOPLE THAT LIVE IN YOUR HOUSEHOLD		
NAME	**Age**	**Relationship to Student**

Student Dental History

Y	N	Dental Practices	Y	N	Dental Problems
		Brushes teeth 2 times a day			Dental disease
		Flossing daily			
Date of last dental exam: _____					

MEDICATIONS

Attached is a list of medications that may be administered only as needed by medical and/or nursing personnel at the School Based Health Center. Some medications may be substituted with a generic form. Please notify the School Based Health Center in writing below if there are any medications you **DO NOT** want your child to receive.

IMMUNIZATIONS

The School Based Health Center provides immunizations through the Vaccines for Children Program. Please notify the School Based Health Center in writing below if there are any immunizations you **DO NOT** want your child to receive.

_____

_____

_____

_____

STUDENT NAME: _____ DOB: _____ GRADE: _____

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the Office of Public Health (OPH) Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school based health centers. We recognize that the information needed by OPH may be compiled through HIE and consent to the disclosure of information to HIE for such purpose.

Confidentiality: The SBHCs adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between DCHC's SBHCs, and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that DCHC SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the Delhi Community SBHC. My signature constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

I understand that my health information is stored in a unified electronic medical record system (Athena) owned and operated by the DCHC's SBHCs which is sponsored by the Hospital Service District 1A. The Notice of Privacy Practices describes how my health information may be used or disclosed by the DCHC SBHC. I understand that I should read it carefully and I am aware that the Notice may be changed at any time.

I understand that I have the right to opt in or opt out of participation in sharing information with participating organizations. I have the right to revoke consent any time, or if I have previously chosen to opt out, I have the right to change my mind and opt in at any time. Option choices must be in writing.

We consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the school nurse program and the health center staff as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal.

The school board and the school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than (1) a health care provider (for diagnosis, treatment, or counseling purposes); (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate consent given on the form.

STUDENT NAME: _____ DOB: _____ GRADE: _____

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that Delhi Community Health Center (DCHC) or the health care provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Delhi Community Health Center.

Louisiana Law R.S. 40:31.3 prohibits health centers in schools from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

DELHI ELEMENTARY/HIGH SCHOOL: To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

DELHI MIDDLE SCHOOL AND DELHI CHARTER SCHOOL: To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact Monica Hales, APRN, FNP-C, SBHC Program Director at 318-878-8965.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled at DCHC School Based Health Center unless the SBHC is notified in writing that I no longer wish for my child to receive services. I understand that I must complete a new consent form at the beginning of each school year to update important information. I also understand that a transfer of schools at any time within the school year requires a new consent form to be completed at the new school of enrollment.

We understand that the SBHC is funded through Louisiana Clinical Services and Delhi Community Health Center. We also understand that the school-based health center is operated by Delhi Community Health Center and its employees and contractors.

_____ Relationship: _____
Printed Name of Parent/Legal Guardian/Student

_____ Date: _____
Signature of Parent/Legal Guardian

_____ Date: _____
Signature of Student (optional)

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

DCHC SCHOOL BASED HEALTH CENTER
MEDICATION LIST
2021-2022

The following is a list of medications that may be administered only as needed by School Based Health Center Staff. Generic and brand name forms may be substituted. Please notify the SBHC in writing of any medication that you do not want your child to receive. Please contact your child's School Based Health Center for any further questions or concerns.

CIRCLE medications you DO NOT want your child to receive.

AFRIN	HYDROGEN PEROXIDE
ALBUTEROL	IBUPROFEN
ANBESOL	IMODIUM AD
ASPERCREAM	LORATADINE
AZITHROMYCIN	LOTRIMIN CREAM
BENADRYL	MAALOX
CALAMINE/CALADRYL LOTION	NEOSPORIN
CELESTONE	PEPTO BISMOL
COUGH DROPS	ROCEPHIN
DELSYM	SILVADENE CREAM
DEXAMETHASONE	STING EASE
DIMETAPP	SIMETHICONE
EMETROL	TORADOL
EUCERINE CREAM	TUSSIN
EYE STREAM	TYLENOL
HIBICLENS	VISINE
HYDROCORTISONE CREAM	ZYRTEC

STUDENT NAME: _____ DOB: _____ GRADE: ____

DELHI COMMUNITY HEALTH CENTER
SCHOOL BASED HEALTH CENTER
Telemedicine Patient Consent Form

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. Telemedicine may be utilized via audio-visual telecommunication link or an audio only link. I understand that in the medical opinion of my healthcare provider the delivery of services via telemedicine will be consistent with the standard of care for an in-person visit. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me/my child to see a specialist in person. My health care provider has explained to me how the video conferencing technology will be used and that there may be limitations and restrictions to the visit which include, for example: no physical examination being conducted and no instruments will be used such as stethoscopes, otoscopes.

I understand there are potential risks to this technology, such as interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I am aware of how to contact my provider in the event technical difficulties do occur as well as for follow up, emergency care or to obtain copies of my medical records.

By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

Patient Consent To Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of patient (or parent/guardian): _____ Date: _____
Please print the above name: _____
Signature of witness: _____ Date: _____

( ) (CHECK AND SIGN BELOW FOR WITHDRAWAL ONLY). I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____ Date: _____
Signature of witness: _____

Delhi Elementary/High School-Based Health Clinic
Release of Information

I hereby authorize the Delhi Elementary/High School-Based Health Clinic (SBHC) to disclose the Personal Health Information (PHI) of student name listed below:

_____	_____	_____
Student Name	**Date of Birth**	**ID#**

The student's PHI that may be disclosed under this Authorization includes records and reports of medical services provided to the student at the SBHC, including but not limited to the evaluation, diagnosis and treatment of the student's injuries and illnesses. The PHI may be disclosed for clinic administration purposes, to the Delhi Elementary/High School administration or staff to evaluate the student's eligibility to participate in school activities, or to resolve grievances. In addition, I give my consent to the School-Based Health Clinic staff to look at my child's full school record, including attendance, in order to provide information that may assist the clinic staff in helping my child. I understand that the Clinic will not restrict services to the student based on my decision not to sign this Authorization, but that the student's participation in certain school sponsored activities may be conditioned on the signing of this Authorization.

Expiration of Authorization Date/Event: _____

As listed above. I understand that I may revoke this Authorization in writing at any time prior to its expiration date, except to the extent that action has been taken by the Clinic in reliance on this Authorization, by sending a written revocation to a member of the Clinic staff. I understand that the PHI released by the Clinic may be subject to re-disclosure by any recipient and no longer protected by federal or state privacy laws.

Parent/Guardian Signature: _____ Date: _____

Signature of Student (if 18 or older or legally emancipated):

_____ Date: _____