Norwalk Community Health Center School-Based Health & Wellness Center
Sites: Brien McMahon & CGS

Parents/Guardians:

The McMahon/CGS Health and Wellness Center is a partnership between Brien McMahon, Center for Global Studies and Norwalk Community Health Center. This letter is an invitation to sign up your child for the Health & Wellness Center (HWC)!

Health care in the HWC is provided by a multi-disciplinary team. A Nurse Practitioner or Physician Assistant, a Licensed Clinical Social Worker/Licensed Professional Counselor of Behavioral Health, and a Psychiatrist provide care at your child's school. We invite you to select all services that your child may need during their years high school.

To sign up your child for the SBHC services:
Up-to-date insurance information is needed if your child is insured. *No co-pay, co -insurance or deductible will be charged on site but will be billed to you after we have submitted services to your medical insurance and after receiving correspondence back from your insurance. No one will be turned away based on ability to pay.*

- **FOR NEW PATIENTS TO NCHC:**
  - Please review, fill out and sign the attached Consent Form choosing which services your child has permission to receive while they are students at McMahon or CGS
  - Fill out attached **Student Registration Form** and **Health History Form**
- **FOR EXISTING PATIENTS TO NCHC:** Please sign and return **Pages 2 & 3**
- Return completed enrollment/registration forms to the HWC, nurses office or administrative office.

SBHC services offered:

- Counseling (individual, family, and group)
- Chronic Disease Management (such as Asthma, Eczema) if NCHC is your Primary Care Provider
- Health education/risk reduction
- Crisis intervention and suicide prevention
- Nutrition/weight management
- Physicals (sports, school, or pre-employment)
- Health screenings
- Immunizations
- Reproductive Health
- Diagnosis and treatment of minor illnesses/injuries
- Anti-Bullying Didactic Services

Please know that your child's pediatrician or family provider is still your child's main provider. HWC does not take the place of your child's pediatrician or family provider, and HWC providers and nurses will work with your child's main provider to care for your child. The HWC offers services that may round out the care provided by your main provider. When appropriate, and with your permission, we will try to share medical information with your child's doctor to prevent any duplication of health care services, and to take the best care of your child. If your child does not have a doctor, we can help you find one.

The HWC staff thanks you for your time. Together with you and your child's main doctor, we will work towards keeping your child healthy and in school. Please encourage your child's pediatrician or family doctor to call the HWC with questions. **If you have questions or need more information, please call Health & Wellness Center at 203-854-0524**

Rebecca Kaplan APRN, Director of Clinical Operations
Ernesta Gadalla, Director of Nursing

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SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES

I, _____, give my consent for_____
(Parent/Legal Guardian of Student) **(Name of Student)**

to receive health services administered by Norwalk Community Health Center at the following **School-Based Health & Wellness Center:**

☐ **Brien McMahon**
☐ **Center for Global Studies (CGS)**

If your student should request any of the following services, do they have your permission to receive them?

MENU OF SERVICES	**CONSENT GIVEN**
PHYSICAL HEALTH	**(CIRCLE ONE)**
• Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury (May include a urinalysis, throat culture, limited blood tests, dispensing non-prescription medication and/or providing prescription medication)	YES NO
• Physical examinations, including sports/employment physical	YES NO
• Immunizations in accordance with the Division of Public Health	YES NO
• Nutrition counseling	YES NO
BEHAVIORAL HEALTH	
• Therapy services	YES NO
EDUCATION	
• Individual and group programs focusing on healthy life choices	YES NO
• Individual and group program focusing on anti-bullying didactics	YES NO

CONFIDENTIAL SERVICES

The following confidential services are offered by this School-Based Health Center. If you consent to your child receiving confidential services at the School-Based Health Center, then according to Connecticut Law (CGS § 19a-216,) you **do not** have the right to information about these services unless your child gives the School-Based Health Center permission to share that information.

- Pregnancy testing
- Diagnosis and treatment of sexually transmitted diseases

The School-Based Health & Wellness Center does not provide the following services

- Treatment or testing of complex medical or psychiatric conditions
- Complex lab tests
- Hospitalization
- X-Rays

PLEASE COMPLETE OTHER SIDE

I understand that Norwalk Community Health Center, retains administrative authority over, and provides partial funding for, the School-Based Health & Wellness Center. Designated School-Based Health Center team members are obligated by law to disclose specific patient information to DPH, for the purpose of preventing or controlling disease, injury, surveillance, or disability in Connecticut as well as in the United States. Such information mandated and required by law includes: sexually transmitted disease;

laboratory data; births; deaths; adverse medication reactions; child abuse or neglect; and domestic violence. Other general information will also be sent to DPH for statistical tracking, but this information will be de-identified which means that my student's name will be removed.

I have had the opportunity to receive and review the Norwalk Community Health Center Notice of Privacy Practices.

I understand that the School-Based Health & Wellness Center may use telemedicine to provide behavioral health and medical services. The video conference between student and provider does not involve data storage, recording, or archiving. Telemedicine encounters would still be subject to the requirements of the HIPAA Privacy Rule that applies to Protected Health Information.

I understand that insurance may be billed for covered services and the need to provide insurance information before services are provided.

I understand in accordance with HIPPA & FERPA I consent to the school nurse, social worker, and/or psychologist communicating directly with the HWC staff for continuity of care and the HWC staff communicating with the school nurse, social worker and/or psychologist directly.

I understand that the Health & Wellness center shall not charge co-pays or any other out-of-pocket fees for use of School-Based Health Center Services.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the School-Based Health Center associated with my student's care.

I understand if I have an outside Primary Care Provider I consent to release of information directly to my Primary Care Provider for continuity of care and will list their name on the Patient Registration Form.

I acknowledge that all information requested on the registration Health History Form and this consent is accurate and complete. My student and I have read this form carefully and I understand that if I have any questions I may call the School-Based Health Center Coordinator for any explanation(s) before I sign this authorization.

By my signature below I certify, as the parent or legal guardian of the student named above, I understand the School-Based Health Center consent for treatment. **This consent is valid for 2 years from date of signature.**

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Student Date

_____
Print Name of Student

_____
Street Address

_____
City State Zip Code

PATIENT REGISTRATION FORM

Patient (Student) Information - Please Print *(in pen)* Grade: K 1 2 3 4 5 6 7 8

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Patient's Last Name:	**First:**	**Middle:**	**Male** ☐	**Female** ☐
Address:	**City**	**State**	**Zip Code**	**Birthdate**

Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native	**Ethnicity** (please circle): Hispanic/Latino Arabic Non-hispanic/latino/arabic
Primary Care Provider (Family Doctor) **Name:** _____ **Phone Number:** _____	**Student's Cell Phone#:** _____
In case of an emergency contact: _____ **Relationship to patient:**_____ **Phone #:**_____	**Is patient employed?** Yes No

Parental/Legal Guardian Information

Mother's Full Legal Name:	
Address:	Home Phone#:
Parent Email Address:	Cell Phone#:
Employer Name & Address:	Work Phone#:
Father's Full Legal Name:	Home Phone#:
Address:	Cell Phone#:
Employer Name & Address:	Work Phone#:
Legal Guardian Name (if not mother or father): **Relationship to Student**	Home Phone#:
Address:	Cell Phone#:
Employer Name & Address:	Work Phone#:

►Insurance Information (REQUIRED) – *Send in a Copy Front and Back of Insurance Card*

Source of payment for care, please check off one of the following:	***Secondary Insurance Information:***
No Insurance_____Medicaid: (Please circle)	**Medicaid: (Please circle)**
Medicaid Number: _____	**Medicaid Number:** _____
Commercial Insurance : _____ **Policy Number:** _____ **Subscriber Name:** _____ **Relationship to Student**: _____ **Subscriber Birthdate:** _____	**Commercial Insurance:** _____ **Policy Number:** _____ **Subscriber Name:** _____ **Relationship to Student**: _____ **Subscriber Birthdate:** _____

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Norwalk Community Health Center School-Based Health Center
HEALTH HISTORY FORM

A complete and accurate health history is needed in order for HWC staff to provide high quality care. Services will not be provided unless this form is complete. **A Parent/Legal Guardian must complete this form in pen.** Please print all information.

Student's Name _____DOB_____Grade _____ ☐ Female ☐ Male
(Last) (First) (MI)

Does your child have any allergies? (food, medication, latex)

☐ Yes ☐ No If yes, please list? _____

Please provide the following information about medicines your child is taking.

Name of medicines	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been hospitalized overnight?

☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

Has your child ever had any serious injuries/illness?

☐Yes ☐No If yes, please explain._____

Has your child been seen by a health care provider in the past year? Name of provider: _____

☐ Yes ☐ No If yes, please indicate the number of visits: _____ Phone#: _____

Reason(s) for visit(s): _____

Has your child been seen in an emergency room within the last year?

☐ Yes ☐ No If yes, please indicate the number of visits: _____

Reason(s) for visit(s): _____

Has your child been seen for a dental visit in the last year?

☐ Yes ☐ No Name of Dentist: _____

Has your child ever been hospitalized or received counseling for emotional health?

☐ Yes ☐ No If yes, when? _____ Where? _____

Reason: _____

PLEASE COMPLETE OTHER SIDE

Please indicate which of the following your **CHILD** has ever had:

☐ Acne/Skin Problems	☐ Diabetes	☐ Hepatitis	☐ Sickle Cell
☐ ADHD/learning disability	☐ Depression	☐ High Blood Pressure	☐ Sleeping Problems

☐ Anemia	☐ Fainting Spells	☐ High Cholesterol	☐ Sports Injury
☐ Anxiety	☐ Frequent Colds	☐ Kidney/Bladder Disease	☐ Stomach/Intestinal Problems
☐ Arthritis	☐ Headaches	☐ Pregnancy/Child Birth/Miscarriage	☐ Suicide Attempts
☐ Asthma	☐ Head Injury	☐ Rheumatic Heart Disease	☐ Suicidal Thoughts
☐ Cancer	☐ Heart Disease	☐ Scoliosis	☐ Substance Abuse
☐ Chicken Pox	☐ Heart Murmur	☐ Seasonal Allergies	☐ Thyroid Disease
☐ Cystic Fibrosis	☐ Hemophilia	☐ Seizures	☐ Tuberculosis

If any of the above is checked, please give more detail._____

_____

In the **past year**, have there been any changes in your family such as:

☐ Marriage	☐ Serious Illness	☐ Change in school	☐ Births	☐ Divorce
☐ Separation	☐ Loss of Job	☐ Move to a new house	☐ Deaths	☐ Other

Please check any of the following illnesses that your **FAMILY MEMBERS** (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and indicate which family member next to the illness.

☐ ADHD/learning disability_____		☐ Obesity _____
☐ Alcoholism/Drug Abuse_____		☐ Seizures_____
☐ Anemia _____	☐ Headaches _____	☐ Sickle Cell_____
☐ Arthritis _____	☐ Heart Disease_____	☐ Stroke_____
☐ Asthma_____	☐ High Blood Pressure _____	☐ Thyroid Disease_____
☐ Birth defects_____	☐ Hemophilia _____	☐ Tuberculosis_____
☐ Cancer_____	☐ Hepatitis _____	☐ Unexplained Death_____
☐ Cystic Fibrosis_____	☐ High Cholesterol _____	☐ Other_____
☐ Deafness _____	☐ Kidney/Bladder Disease_____	
☐ Diabetes _____	☐ Mental Illness_____	

PARENTAL/GUARDIAN CONCERNS

Below are some common concerns of adolescents and families. If you have any of these concerns, please encourage your child to schedule a visit at the Wellness Center or you can feel free to call the Wellness Center to discuss your concerns.

Weight/Diet/nutrition	Violence
Sleep Patterns	School grades truancy/dropout
Smoking cigarettes/chewing tobacco	Relationships with family members
Choice of friends	Drug/Alcohol use
Self image/self worth	Sexual behaviors
Depression	Sexual identity
Lying, Stealing, or vandalism	Excessive moodiness or rebellion

If you would like assistance with establishing Insurance, finding a doctor, or a dentist, please call the School-Based Health Center.

Name of person completing this form: _____

Relationship to student: _____Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Norwalk Community Health Center School-Based Health & Wellness Center Sites: Brien McMahon & CGS

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerns or objections to this form, please ask to speak with our Director of Quality, Risk & Compliance.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.