



**JEFFERSON SCHOOL BASED HEALTH CENTERS**  
*For more information contact Jefferson County Public Health (360) 385-9400*  
**GENERAL CONSENT FOR SERVICES**

Student Name (please print)

Date of Birth

I give permission to Jefferson School Based Health Center to perform such medical and therapeutic procedures as may be professionally necessary or advisable for me (or my child's) health screening, diagnosis and treatment. I understand that a patient record will exist for each student. This consent allows services and information to be authorized and shared between Jefferson Healthcare, Jefferson County Public Health and Counseling Services within the clinic.

I understand the following types of services are offered through the School Based Health Clinic (SBHC):

- ◇ Routine physical exams, including sports physicals
- ◇ Diagnosis and treatment of acute and chronic illness
- ◇ Laboratory tests
- ◇ Reproductive health services, e.g. counseling, education, exams, and referrals
- ◇ Immunizations
- ◇ Health education, counseling, and wellness promotion
- ◇ Nutrition and health education, wellness counseling
- ◇ Mental health services offered by MCS Counseling Services
- ◇ Referral for health care services which cannot be provided at the School Based Health Center
- ◇ Dental services, referrals

**STATEMENT OF STUDENT CONFIDENTIALITY AND RIGHTS**

Services provided at Jefferson School Based Health Center (SBHC) must have a signed consent form from a parent or legal guardian before health services are provided to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. According to the law, minors may provide their own consent for alcohol and drug treatment and mental health treatment at age 13 or older and reproductive health care at any age. If necessary, the SBHC will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

The youth's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), alcohol and drug treatment, or mental health counseling.

When a person consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- ◇ If the client gives us permission through a signed release of information.
- ◇ If student shows risk of suicidal behavior.
- ◇ If student plans to do serious bodily harm to another person.
- ◇ If student has a life threatening health problem **and is under 18 years of age.**
- ◇ If there is reason to suspect abuse or neglect. This *may* include any sexual contact with a minor (any person under the age of 18 years) by a person over 18 years old or where there is a three (3) year or greater age difference.

All information and services received are confidential.

The School Based Health Center encourages all students to involve their parents or guardians in their health care decisions whenever possible. This consent expires when the student is no longer enrolled in the Port Townsend, Chimacum or Quilcene School District.

Student Signature

DOB

Phone

Date

Parent or Legal Guardian Name (Please Print)

Relationship to Student

Parent or Legal Guardian Signature

Phone

Date

# SCHOOL BASED HEALTH CENTER—REGISTRATION FORM

Please help us serve you better and comply with our reporting requirements by providing the following confidential information.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Please print Last First Middle*

Student's Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Gender:  Male  Female  Other

Which of the following best describes the student's race? (check one):

- African American/African Native  American Indian/Alaskan Native  Asian  
 Spanish/Hispanic/Latino  Pacific Islander  White  Multi-Racial

## Supplemental Information

Who referred the student to the clinic?: \_\_\_\_\_ Student's Grade: \_\_\_\_\_

List activities in which the student is involved: \_\_\_\_\_

## Medical/ Mental Health History

Does the student have a doctor?  Yes  No If yes, please provide name and phone number: \_\_\_\_\_

Does the student have any medical problems or mental health concerns?: \_\_\_\_\_

Does the student need medication on a regular basis?: \_\_\_\_\_ What?: \_\_\_\_\_

Has the student ever had any surgery, serious illness, injury or ongoing illness?: \_\_\_\_\_

Does the student have allergies to any medications?: \_\_\_\_\_

Has the student or any family member had the following? (Check all that apply)

- Asthma  Diabetes  Heart Problems/Stroke  Mental Health Problems  Alcohol or Chemical use  
 Cancer  Seizures  High Blood Pressure  High Cholesterol  Died Before Age 50

## Fees and Billing

The Health Center relies on client fees and insurance/Medicaid billing to be able to offer quality services to students. If your student does not have insurance, we can send you the enrollment information for the State Children's Health Insurance Program. **No one will be denied services due to inability to pay**, but the following information is **required** so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information, we will bill you at full fee for service.

## Sliding Fee Scale

Do you want to apply for a sliding fee adjustment based on income? \_\_\_ Yes \_\_\_ No

If yes, provide us your GROSS monthly household income (including unemployment, child support, workers compensation, social security, self employment income, DSHS, AFDC checks, interest income, and partner's income). \$ \_\_\_\_\_

Number of people supported by this income. \_\_\_\_\_

## Insurance Information

Is the student insured?  Yes  No insurance  Don't Know

Plan Type:  Medicaid/Healthy Options  Basic Health Plan  Private/Commercial

Insurance /Plan Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber Relationship to Patient: \_\_\_\_\_  
(Parent/Guardian/Self)

Consent to Release Information to Insurance Carrier: I certify the information supplied above is accurate. I authorize release of medical and related information to my health insurance company or other third party payer for the purpose of obtaining payment for services rendered. Policies are in place to assure privacy is maintained related to confidential services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

