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 Jefferson Mental Health 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 Jefferson Mental Health Services
- ◊ Referral for health care services which cannot be provided at the School Based Health Center
- ◊ Dental services e.g., screening, cleaning and 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.

____ Please initial here to give consent to release SCAT 3 (baseline concussion assessment) to school and primary care provider.

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 or Chimacum School District.

Student Signature _____ Phone _____ Date _____

Parent or Legal Guardian Name (Please Print) _____ Relationship to Student _____

Parent or Legal Guardian Signature _____ Phone _____ Date _____

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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

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 family does not have health insurance see website: wahealthplanfinder.org to see if you qualify for an affordable state plan. ***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/Apple Health ☐ 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: _____

Over for General Consent for Services Form →