JEFFERSON PARISH
School-Based
Health Centers

JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS

WEST JEFFERSON SCHOOL-BASED HEALTH CENTER
2200 Eighth Street
Harvey, LA 70065
Phone: (504) 367-4407
Fax: (504) 367-4327

Dear Parent/ Guardian:

The health center will be open again this year for students of West Jefferson High School. Our licensed medical staff will be here to treat your child for any health issue that may arise at school.

The health center's staff consists of a registered nurse, a medical doctor, a nurse practitioner, and a social worker. The registered nurse, nurse practitioner, and social worker are at the clinic on weekdays when school is in session. The clinic hours are 7:15 a.m. to 2:40 p.m. The medical doctor is in the health center on Wednesdays until noon.

The school-based health center will be able to provide medical services such as sports or comprehensive physicals, immunizations, and lab work. The medical staff will be able to assess students who are sick and give over the counter medicines if needed. The social worker is available to provide assessments, education, and counseling as needed. The purpose of the health center is to keep students at school and to allow parents to stay at work. Health centers are in numerous schools around the state and have been providing services successfully to students for over 20 years.

Please fill out the attached consent form carefully if you would like to take advantage of the clinic. A parent or guardian must be the one to print and sign their name on the consent form. Your child cannot be seen in the Health Center without a completed consent form. If the consent form is incomplete, it will be returned for completion.

The consent form will be effective for the entire time that your child is enrolled in a Jefferson Parish Public School System school that is served by the Jefferson Parish School-Based Health Centers. We will send you a one page form every year to update addresses, phone numbers and allergies.

If you have any questions, please feel free to call the Health Center at 367-4407.

Angie Ruiz, LCSW
Director of Jefferson Parish
School-Based Health Centers

JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS
WEST JEFFERSON SCHOOL-BASED HEALTH CENTER
2014-2015

Student's Name: Last	First	Middle Initial			ID# (Office use only.)
Student's Address (include city):					Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Race:	Ethnicity:	
Student's Social Security Number:	School:			Student's Grade:	
Preferred Language:	Student's Email:			Student's Cell Phone: ( )	
Name of Mother (include maiden name) or Legal Guardian:	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:				Phone: ( )	
Student's Dentist:				Phone: ( )	

Preferred Pharmacy: _____

Phone Number: _____ **Address:** _____

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/Bayou Health Plan #: _____ (check one below)

❑ Amerigroup ❑ Community Health Solutions ❑ LaCare

❑ LA Health Connections ❑ United Healthcare

❑ 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 health 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 student is on with dosage (how much) and how often:

LAHIE Statement: **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 SBHC is funded through the Office of Public Health ("OPH") Adolescent School Health Program 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 a HIE and consent to the disclosure of information to a HIE for such purpose.

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

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 and injury including medications, if indicated. ♦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 (where available)

Student's Name:_____ **Date of Birth:**_____

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 West Jefferson School-Based Health Center or the physician may bill Medicaid or other insurance providers for these services. West Jefferson School-Based Health Center will contract with Access Health Louisiana for mental health services provided. West Jefferson School-Based Health Center will bill for medical services and Access Health Louisiana will bill for mental health services. Therefore, I authorize/assign payments of authorized benefits for medical services directly to West Jefferson School-Based Health Center and benefits for mental health services directly to Access Health Louisiana.

We (student and parent/guardian) 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. We (student and parent/guardian) understand that the SBHC staff may refuse services to any student who is disrespectful in any way to any SBHC staff member.

We also understand that the school health center is operated by Jefferson Parish Public School System and its employees and contractors, Access Health Louisiana.

"I, as parent/guardian, understand that the SBHC will disclose my child's health information to the Greater New Orleans Health Information Exchange (GNOHIE) and/or the Louisiana Health Information Exchange (LaHIE). The purpose of such disclosure is so that the GNOHIE and/or LaHIE can assist the SBHC with its' reporting requirements to the State"

I have received a copy of the Notice of Privacy Practices.

This consent is valid for the entire time the student is enrolled in a Jefferson Parish Public School System school served by one of the Jefferson Parish School-Based Health Centers.

_____ Relationship: _____
Printed Name of Parent/Legal Guardian

_____ Date: _____
Signature of Parent/Legal Guardian

_____ Date: _____
Printed Name of Student (if over 18 years old)

_____ Position: _____
Printed Name of School Health Witness/Verify

_____ Date: _____
Signature of School Health Witness/Verify

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.

Louisiana state law 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. This includes the morning-after abortion bill.

To report violation 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 504-568-8161.

MEDICAL HISTORY

FAMILY HISTORY

Please mark the items that apply to your family's medical history.

_____ SUBSTANCE ABUSE	_____ SEIZURES	_____ GENETIC DISORDER
_____ MENTAL DISORDER	_____ TUBERCULOSIS	_____ ANEMIA
_____ ASTHMA	_____ CANCER	_____ DIABETES
_____ ALLERGIES	_____ HEART DISEASE	_____ STROKE
_____ HIGH BLOOD PRESSURE		

OTHER (specify)_____

Please describe any item marked above (WHO/WHEN):

PATIENT HISTORY

Please mark any items that apply to your child's medical history.

_____ ALLERGIES	_____ MAJOR INJURIES	_____ BIRTH DEFECT
_____ ASTHMA	_____ TONSILLITIS	_____ SPEECH PROBLEM
_____ KIDNEY DISEASE	_____ EAR INFECTION	_____ MENTAL DISORDER
_____ ENDOCRINE (GLANDS)	_____ MENINGITIS	_____ SUBSTANCE ABUSE
_____ CHICKEN POX (If no, vaccine received_____)		_____ HEART DISEASE

OTHER (specify)_____

Please describe any item marked above (WHO/WHEN):

HOSPITALIZATION INFORMATION: Has your child ever been admitted to a hospital for a medical or mental health condition?

YES **NO** (circle one) If yes: Year_____ Hospital_____

Reason:_____

MENTAL HEALTH

Are there any mental health issues or concerns at this time? YES NO _____

Any special needs that we should be aware of?_____

Student's Name:_____ **Date of Birth:**_____

JEFFERSON PARISH SCHOOL BASED HEALTH CENTERS
OVER THE COUNTER MEDICATIONS

The following over the counter medications* have been approved by the physician of the Health Center to be administered to your child by the Registered Nurse if needed:

Acetaminophen (Tylenol)
Ammonia Inhalants
Anti-nausea Liquid (Emetrol)
Bacitracin
Bactine Spray
Benadryl (Dipenhydramine)
Benzoin Topical
Betadine Solution
Caladryl Clear
Calamine Lotion
Chloraseptic Spray
Colace
Contact Lens Solution
Cough Drops
Debrox (Ear Wax Removal Drops)
Eye Wash Solution
Glucose Gel or Tablets
Guaifenesin
Guaifenesin DM
Hydrocortisone 1% Cream or Ointment
Hydrogen Peroxide
Ibuprofen (Advil)
Isopropyl Alcohol
Loratadine (Claritin)
Lotramin AF
Maalox
Medicaine
Mylanta
Nasal Relief Spray
Natural Tears
Neosporin
Oral Pain Relief Gel (Orajel or Anbesol)
Pepto Bismol
Sore Throat Lozenges
Sterile Water
Stik It Skin Adherent
Sudafed PE (Phenylephrine HCl 10 mg Tabs)
Vaseline
Vitamin A&D Ointment

*Generic form of medication may be substituted.

I agree that this student may receive all of the medications offered at the school-based health center except those which I have written here:

_____

Parent's or guardian's Signature

Student's Name:_____ **Date of Birth:**_____

Jefferson Parish School-Based Health Centers

NOTICE OF PRIVACY PRACTICES

Effective 4/14/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMANTION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMANTION PLEASE REVIEW IT CAREFULLY

If you have any questions, please contact our Privacy Office at the address or phone number at the end of this Notice.

WHO WILL FOLLOW THIS NOTICE?

Jefferson Parish Health Centers provides health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- Any health care professional who treats you at any of our locations;
- All departments and units of our organization
- All employed associates, staff or volunteers of our organization,
- Any business associate or partner of Jefferson Parish School-Based Health Centers with whom we share health information.

OUR PLEDGE TO YOU

We understand that medical and billing information about you is personal. We are committed to protecting the privacy of your medical and billing information. We create a designated record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or Notices regarding the doctor's use and disclosure of your medical and billing information created in the doctor's office. We are required by law to:

- Keep medical and billing information about you private;
- Give you this Notice of our legal duties and privacy practices with respect to your protected health information;
- Follow the terms of the Notice currently in effect.

CHANGES TO THIS NOTICE

We may change our policies and privacy practices at any time. Changes will apply to your protected health information we already hold, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our Notice and post the new Notice in waiting area, and exam rooms. You can receive a copy of the current Notice at any time. The effective date is listed just below the title

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

- We may use and disclose medical and billing information about you for **treatment** (such as sending medical information about you to a specialist as part of a referral**); to obtain payment for treatment** (such as sending billing information to your insurance company or Medicaid and **to support our health care operations** (such as comparing patient data to improve treatment methods.)

- We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected health information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, or during emergencies.** We may also disclose protected health information **when required by law**, such as in response to request from law enforcement officials in specific circumstances, or in response to valid judicial or administrative orders.

- We may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services that may be of interest to you.**

- We may disclose medical and billing information about you to a **friend or family member who is involved in your medical care** or to disaster relief authorities so that your family can be notified of your location and condition.

Student's Name:_____ **Date of Birth:**_____

OTHER USES OF MEDICAL INFORMATION

- In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing your protected health information. If you choose to authorize our use or disclosure or your protected health information, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- In most cases, **you have the right to look at or obtain a copy of medical and billing information** contained in the designated record set that we use to make decisions about your care. If you request copies, we may charge a fee for the cost of copying, related supplies or postage. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your designated record set is incorrect or if important information is missing, **you have the right to request that we correct the records.** Your request may be submitted in writing. A request for amendment must provide your reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determined that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

- **You have the right to a list of those instances where we have disclosed medical and billing information about you,** other than for treatment, payment, health care operations or where you specifically authorized a disclosure. When you submit a written request, the request must state the time period desired for the accounting, which must be less than a six (6)- year period and starting after April 14, 2003.The first disclosure will be provide to you at no cost; other request will be charged in accordance with our cost to produce the list. We will inform you of the cost before your incur any charges.

- **You have the right to request that your medical and billing information be communicated to you in confidential manner**, such as sending mail to an address other that your home. You must notify us in writing of the specific way or location for us to use to communicate with you.

- **You may request in writing, that we not use or disclose protected health information about you** for treatment, payment or healthcare operation or to persons involved in your care except when specifically authorized by you, or when required by law, or in an emergency. We will consider your **request but we are not legally required to accept it.** We will inform you of our decision.

- **All written request or appeals should be submitted to our Privacy Office listed at the end of this Notice.**

COMPLAINTS

- If you are concerned that your privacy right may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy office (listed below).

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office Civil Rights. Our Privacy Office will provide you the address upon request.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

PRIVACY OFFICE CONTACT INFORMATION
Angie Ruiz
Jefferson Parish School Based Health Centers
2801Bruin Drive
Kenner, La. 70065
504-303-6803
504-303-6804 Fax

Student's Name:_____ **Date of Birth:**_____