SCHOOL-BASED HEALTH CENTERS
Consent for Services Information

The School-Based Health Centers are a joint effort of Optimus Health Care, Southwest Community Health Centers and the State of Connecticut and the Bridgeport Board of Education. Currently there are School Based Health Centers located in each of the high schools in Bridgeport and multiple elementary schools. *(See list of schools on back side.)*

WHAT IS A SCHOOL-BASED HEALTH CENTER? A comprehensive, primary health care center located in a school. Staff include: medical providers such as nurse practitioners, physician assistants, pediatricians, dentists, dental hygienists, dental assistants, medical assistants and, social workers.

WHAT DO SCHOOL-BASED HEALTH CENTERS DO? School-Based Health Centers provide a limited variety of services, including physical exams; health care services for students who are sick (co-management with a child's primary care provider on most health related issues) including asthma and diabetes; immunization updates; individual, group and family counseling, parent guidance; classroom education on wellness issues; crisis intervention; reproductive health services including: gynecological exams (Pap smears and sexually transmitted infections screenings); diagnosis and treatment of sexually transmitted diseases; condom availability and prescription of birth control; dental care services including cleanings, fillings, and extractions. Referrals are made to community providers as needed.

HOW CAN A STUDENT USE THE HEALTH CENTER? A student must have a consent form signed by his/her parent or guardian in order to receive health center services. If the student is 18 years old or older or emancipated, he/she can sign his/her own Consent for Services form. The Consent for Services form is valid for **two academic school years** and a new consent will be sent home prior to the expiration date to ensure your child remains an active member of the School Based Health centers.

HOW ARE THE SERVICES PAID FOR? Optimus Health Care, Southwest Community Health Center and the State of Connecticut contribute funds for the operation of these health centers. Billing of third party insurers will assist us in covering the costs of operating the School-Based Health Centers. **You or your child will not be charged directly for any services**. Students and families without any insurance coverage will not be charged.

The School-Based Health Centers will not be billing parents or students directly for any co-payments required by your insurance, we will not seek payment from you if you have not met your insurance company's deductibles, and will not seek direct payment from you if the claim we submit to an insurance company for services provided is denied by the insurance company. Our billing should not have any impact on the premiums you pay.

ESTA INFORMACIÓN Y LOS CORRESPONDIENTES FORUMLARIOS ESTÁN DISPONIBLES EN ESPANOL Y EN LOS CENTROS DE SALUD ESCOLARES. SI NECESITA TRADUCCIÓN AL ESPANOL, FAVOR DE LLÁMAR Ó PRESENTARSE A UNO DE LOS CENTROS DE SALUD ESCOLARES.

CONFIDENTIALITY: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. The School-Based Health Centers may release information regarding your child and/or services provided in order to bill third party payers including private insurance and Medicaid for services, and for healthcare operations and treatments. Please review the Notice of Privacy Practices, which outlines how we may use and disclose your child's protected health information.

The Board of Education maintains a partnership to ensure access to health care for all students. By operating health centers on school grounds, the School-Based Health Centers accept a unique responsibility to promote a safe and healthy environment for all students. School-Based Health Centers staff will cooperate and communicate with you, the Board of Education staff whenever student behavior/or health may result in risk of harm to the student or others within the educational setting. The health center staff will follow established protocols and policies developed by the School-Based Health Centers as well as those detailed in the Board of Education's Staff Manual and Student Handbook. Completing and signing the Consent for Services form authorizes us to release information as identified in the attached Notice of Privacy.

HOW DO I GET ADDITIONAL INFORMATION ON THE SCHOOL-BASED HEALTH CENTERS?

Please feel free to contact any of the School-Based Health Centers at the following address and phone numbers:

Blackham School
425 Thorme Street
Bridgeport, CT 06606
203.396.8532

Columbus School
275 George Street
Bridgeport, CT 06604
203.576.8462

John F. Kennedy Campus
700 Palisade Avenue
Bridgeport, CT 06610
203.576.7534

Dunbar School
790 Central Avenue
Bridgeport, CT 06607
203.332.4567

Luis Munoz-Marin School
479 Helen Street
Bridgeport, CT 06608
203.576-8310

Read School
130 Ezra Street
Bridgeport, CT 06606
203.275.4724

Roosevelt School
680 Park Avenue
Bridgeport, CT 06604
203.275-2173

Bassick High School
1181 Fairfield Avenue
Bridgeport, CT 06605
203.275.3100

Central High School
1 Lincoln Boulevard
Bridgeport, CT 06606
203.275.1701

Harding High School
1734 Central Avenue
Bridgeport, CT 06610
203.576.8213

Cesar Batalla School
606 Howard Avenue
Bridgeport, CT 06604
203.576.8517

James J. Curiale School
300 Laurel Avenue
Bridgeport, CT 06605
203-576-8437

Fairchild Wheeler High School
840 Old Town Road
Bridgeport, CT 06606

Barnum School
495 Waterview Avenue
Bridgeport, Ct 06608

Waltersville School
150 Hallet Street
Bridgeport, CT 06608

If you have any general questions regarding the School-Based Health Centers, please call the School-Based Health Center directly. We encourage you to complete and sign the Consent for Services and Medical History forms in order for our staff to further assist you and your child.

SOUTHWEST COMMUNITY HEALTH CENTER

OPTIMUS HEALTH CARE

SCHOOL-BASED HEALTH CENTERS CONSENT FOR SERVICES

Please complete all information on the front and back of this permission form in ink; all questions must be answered. You must sign and date it in order for your child to receive services from the School-Based Health Centers. If this form is not fully completed, your child will not be able to receive services unless it is an emergency. If you need help filling out the form, please contact the School Based Health Center. If a student is 18 years old or older or emancipated, he/she can sign his/her own permission form.

Student's name: _____ ☐ Female ☐ Male
Last First Middle

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Social Security No.: _____

Cell Phone (of student): _____ Email address: _____

School: _____ Grade: _____ Homeroom #: _____

Mother/Father or Guardian Name: _____ **Mother/Father or Guardian Work Phone** _____

Mother/Father/Guardian Beeper/Cellular Phone #s: _____ **Mother/Father Date of Birth:** _____

Emergency contact (please note how the person is related to the student):
Contact Name: _____ Phone/Cellular # _____ Relationship _____

Contact Name: _____ Phone/Cellular # _____ Relationship _____

Ethnicity of Student:
☐ Hispanic/Latino ☐ Unknown/Not Reported
☐ Not Hispanic/Latino ☐ Declined to Specify
☐ Other

Racial/Ethnic Background of Student:
☐ American Indian or Alaska Native ☐ Black/African American ☐ Pacific Islander ☐ Unreported/Refused
☐ Asian ☐ Native Hawaiian ☐ White ☐ Other

Source of Medical Care:
Who is your child's Doctor/Clinic: _____ Dentist/Clinic: _____
Address & Phone: _____ Address & Phone: _____

Where do you get your child's medical care?
☐ Community Health Center ☐ No Regular Source ☐ Urgent Care Clinic
☐ Emergency Room ☐ Private Doctor ☐ Unknown
☐ Hospital Clinic ☐ School Based Health Center ☐ Other Type: _____

CONTINUE ON BACK PAGE…

FOR OFFICE USE ONLY:
Consent Date: _____ **SBHC Chart #**: _____ **Date Registered:** _____

Student Grade Information:

Year			
Age			
Grade			
Homeroom			

*****IMPORTANT*** Please provide information regarding your child's Managed Care Company, Private Insurance and/or Dental coverage. Form will be returned if insurance information is not filled in.**

Type of Insurance (check all that apply and complete information below on your child's insurance coverage)

☐ **Medicaid(Title 19)** ☐ **Private/Commercial Insurance** ☐ **Dental** ☐ **No Insurance Coverage**
☐ **Medicaid HUSKY A**
☐ **Medicaid HUSKY B**

MEDICAID(TITLE 19); Medicaid HUSKY A; Medicaid HUSKY B Information:
Child's Medicaid #: _____ Name of Managed Care Company: _____
Child's managed care doctor: _____ Effective Date: _____

PRIMARY INSURANCE INFORMATION:
Policy Holder's Name: _____ Relationship to Student: _____
Policy Holder's Address: _____ Policy Holder's Date of Birth: _____
Policy Holder's Social Security #: _____
Insurance Carrier Name and Address: _____
Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____
Effective Date of Coverage: _____
Policy Holder's Employer Name and Address: _____

DENTAL INSURANCE INFORMATION:
Policy Holder's Name: _____ Relationship to Student: _____
Policy Holder's Address: _____
Policy Holder's Date of Birth _____ Policy Holder's Social Security #: _____
Plan Name: _____ Plan #: _____
Is the Student covered by another dental plan? ☐ Yes ☐ No
If yes, name of plan and address: _____ Plan #: _____

Please provide a copy of your current insurance card(s), Medicaid card, Medicaid Managed Care Plan Card and any claim forms(s) your insurance carrier requires.

Please list the names of other children living in your home; if they attend school please list the school and grade:

_____

_____

_____

I have received the materials regarding the services of the School Based Health Center SBHC including the SBHC Notice of Privacy Practice. In accordance with the State Statute, (Conn. Gen. Stat. 19a-602), by signing this consent form I agree that my child can discuss and receive the above noted services, including reproductive health services. Reproductive health services include: gynecological exams (pap smears and sexually transmitted infections screening); diagnosis and treatment of sexually transmitted infections; condom availability and prescription of birth control without further notification from the School-Based Health Center staff. I give permission to the School Based Health Centers to release information regarding treatment and/or services to my or my child's insurance provider(s) for the purpose of billing. I authorize payments to be made directly to the School Based Health Centers for services provided.

***Please note: If you do not have insurance at the time you sign this consent, but obtain it later, we will bill your insurance company for services provided using your signature below as authorization to bill.**

_____
Parent/Guardian Signature

Consent Valid for two academic years.

_____ **SCHOOL YEAR 2019-2020**
_____ **SCHOOL YEAR 2020-2021**

_____
Relationship to Child

Student Name: _____ **Birth Date:** _____

PAST MEDICAL HISTORY: (please fill in and explain)

Has your child had any medical problems: _____

1. Chronic problems (asthma, diabetes, ADHD, Mental Health, etc. _____
2. Disabilities (special ed./medical etc.) _____
3. Has your child ever been hospitalized/had surgery/been injured: _____
4. Childhood illness: (Chicken pox, measles, mumps, rubella, etc.) _____

Has your child had any of the following: (Please check either "Yes" or "No" for **every** question; if you cannot answer a question please attach a statement explaining why.

Yes	No		Yes	No	
☐	☐	Eating Problems	☐	☐	Pregnant
☐	☐	HIV/AIDS	☐	☐	Seasonal Allergies
☐	☐	Sleeping Problems	☐	☐	Arthritis
☐	☐	Weight Problems	☐	☐	Headaches
☐	☐	Vision Problems	☐	☐	Seizures
☐	☐	Hearing Problems	☐	☐	Blood Disorders (Anemia, Sickle Cell Disease or Trait)
☐	☐	Dental Problems	☐	☐	Clotting Disorders
☐	☐	Skin Disorders (Eczema, Psoriasis)	☐	☐	Attention Deficit Disorder or ADHD
☐	☐	Ear Infections	☐	☐	Depression
☐	☐	Asthma	☐	☐	Mental Illness
☐	☐	Pneumonia	☐	☐	Hernia
☐	☐	Tuberculosis (Contact/Infection)	☐	☐	Diabetes
☐	☐	Heart Problems (Murmur, Rheumatic, Heart Disease)	☐	☐	Thyroid Problems
☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	High Cholesterol	☐	☐	Chicken Pox
☐	☐	Stomach Problems (Diarrhea, Constipation, Pain, Vomiting)	☐	☐	Mononucleosis
☐	☐	Urinary tract Infections	☐	☐	Hepatitis
☐	☐	Menstrual Problems	☐	☐	Meningitis
☐	☐	Lead / Highest level _____	☐	☐	Other: Explain: _____

Is your child taking any medications on an everyday or frequent basis? ☐ Yes ☐ No Explain: _____

Medications can include some of the following: (Please list names)

YES	NO	
☐	☐	Aspirin, Ibuprofen or Tylenol? _____
☐	☐	Oral Contraceptive/Birth Control pills? _____
☐	☐	Antibiotics such as Penicillin, etc.? _____
☐	☐	Mental Health or behavioral medications (i.e. ADHD)? _____
☐	☐	Vitamins (including iron pills)? _____
☐	☐	Asthma Medication? _____
☐	☐	Allergy Medication? _____
☐	☐	TB Medication? _____
☐	☐	Diabetic medications (i.e. insulin)? _____
☐	☐	Other medication? _____

Is your child allergic to or have they had an adverse reaction to:

Yes ☐	No ☐	Betadine or iodine	Yes ☐	No ☐	Local Anesthesia (Novocain, etc.)?
Yes ☐	No ☐	Penicillin or other antibiotics?	Yes ☐	No ☐	Latex or Rubber products?
Yes ☐	No ☐	Sedatives, Barbiturates?	Yes ☐	No ☐	Codeine or other pain killers?
Yes ☐	No ☐	Aspirin or Ibuprofen?	Yes ☐	No ☐	Other: _____

Other allergies or reactions? (include allergies to foods, insects, animals, etc.) Please list:

STUDENT MEDICAL HISTORY (continued)

Please list any concerns you have regarding your child's physical or mental health:

DENTAL HISTORY

Name of Dentist: _____ Child's last dental visit: _____

Do you have any concerns about your child's teeth? _____

Has your child ever had anesthesia (Novocain, Laughing Gas) for dental work? _____
Any problems with anesthesia? _____

(If you have a private dentist, SBHC dentists will only see your child in an EMERGENCY).

If you do not have your own dentist, do you want your child to see the SBHC Dentist? ☐ Yes ☐ No

FAMILY HEALTH HISTORY:
Please check below if any of your child's **BLOOD RELATIVES** (i.e. parents, brothers/sisters, aunts, uncles, grandparents) have had any of the following illnesses and note which relative had them:

YES	NO	ILLNESS	Relative	Explain
☐	☐	Diabetes, Endocrine Disorder (thyroid)		
☐	☐	Cancer		
☐	☐	Heart problem, Stroke		
☐	☐	High Blood Pressure		
☐	☐	Blood Disorders including Anemia		
☐	☐	Clotting Disorders		
☐	☐	Respiratory Problems including Asthma		
☐	☐	Mental Illness (ie. Depression)		
☐	☐	Alcohol/Drug Problems		
☐	☐	Infections (TB/HIV/AIDS)		
☐	☐	Death Under the age of 50		
☐	☐	OTHER:_____		

I have read the materials regarding School Based Health Centers (SBHC) services and received the SBHC Privacy Notice and give my permission for my child to receive SBHC services. This medical history is accurate to the best of my knowledge. I understand I should inform the SBHC staff if there are any changes in my child's mental or physical health.

I give permission for the exchange of relevant medical/mental health information amongst SBHC staff, with Bridgeport Board of Education staff, and with outside providers on an as needed basis based upon the Privacy Notice unless I object in writing. The goal of this process will be to assist in maintaining health and safety in the schools, and to coordinate my child's care. SBHC charts may be transferred to other SBHC clinics and Southwest Community Health Center as needed. I understand this authorization automatically **expires two academic school years** from the date signed unless I withdraw my consent in writing.

_____ _____
Signature **Date**

_____
Relationship