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
205 Broad Street
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

Geraldine W. Johnson School
475 Lexington Avenue
Bridgeport, CT 06604
203.275.2597

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. 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: _____ **DOB:** _____
Last First Middle

Address: _____ **City:** _____ **Zip Code:** _____

Primary Language _____ School: _____ Grade: _____ Homeroom _____

Social Security _____ ☐Female ☐Male ☐Other ☐Decline Home/Cell Phone: _____

Parent/Guardian/Emergency Contact		
Guardian Name:	DOB:	Relationship:
Guardian Email:	Phone:	
Emergency Contact:	Phone:	Relationship:

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

Race/Ethnicity: ☐ American Indian/Alaska Native
☐Asian ☐Black/African American ☐Native Hawaiian ☐White
☐Other ☐Unknown/Not Reported ☐Decline to Specify

Primary Care Physician: _____ Address: _____

Office Number: _____ Fax:_____ Dental Provider:_____

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

Medical/Dental Insurance Information:

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 #: _____

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.

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

Has your child had any medical problems: _____

Has your child had any of the following: (Please check either "Yes" or "No" for **every** question)

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
Please list all medications: _____
Is your child allergic to or have they had an adverse reaction to any medications, foods or insects: ☐ Yes ☐No

If Yes, please explain: _____

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 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; 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 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 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.

Parent Signature: _____ Date: _____

Relationship to Child: _____ **Consent Valid for two academic years.**