SCHOOL BASED HEALTH CENTER PERMISSION FORM
Please Print ONLY in Black Ink

Registration Date _____ Name of School: _____Grade: _____

___ New ___ Revised ___ How did you learn about the School Based Health Center? _____

Please fill out both pages and sign and date page 2 in order for your child to receive services from the School Based Health Center. If a student is 18 or older, he/she can sign his/her own permission form. Claims will be submitted to Medicaid/Title XIX, HUSKY, and private insurance. The Agency will waive any out-of-pocket charges with the exception of services covered by commercial insurance plans which require copays. When this occurs, the billing office will issue an invoice. However, no one will be refused care based on ability to pay.

Student's Name: _____ Female Male
Last First M.I. (circle one)

Parent/Guardian Name (please print) _____

Home Address: _____ Apt#_____

City: _____ Zip Code: _____ Email: _____

Language spoken at home _____

Home Phone #: _____ Cell Phone # _____

Student's Birth Date:____/____/____ Student's Social Security:_____

Ethnicity of Student: ___ Hispanic/Latino ___ Not Hispanic/Latino

Racial Background of Student: **(please check all that apply)**
__ American Indian or Alaska Native
__ Asian
__ Black or African American
__ White
__ Native Hawaiian or Other Pacific Islander
__ Other: (Please write in race if it is not on the list of choices)_____

Approximate Yearly Household Income (***MUST* BE COMPLETED FOR STATISTICAL REPORTING AND IS STRICTLY CONFIDENTIAL)** _____ Total number of people in household _____

Is the student eligible for free or reduced lunch? ___ yes ___ no

Emergency Contact Information: Names of two people whom SBHC may call in an emergency.

Name_____ Relationship_____Telephone_____

Name_____Relationship _____Telephone _____

Allergies: Yes_____ No_____ Food (list) _____
Medicine (list) _____

My child has the following chronic health conditions: _____

Where do you take your child for physicals or sick visits?
___ Community Health Center ___Hospital Clinic ___School Based Health Center ___Military Clinic
___ Emergency Room ___Urgent Care/Walk In Clinic ___ Private Doctor's Office_____

SCHOOL BASED HEALTH CENTER STUDENT INSURANCE INFORMATION

Student's Name:_____ School:_____

Type of Insurances (fill in *ALL* that apply and complete information below on your child's insurance coverage). Please provide a copy of your current insurance card(s), Medicaid Card, Medicaid Managed Care Plan Card and any claim forms your insurance carrier requires. Please advise SBHC of any changes in insurance.

__Commercial __Medicaid/HUSKY __ No Insurance Coverage __Referred to HUSKY

MEDICAID/STATE INSURANCE INFORMATION:

Child's Medicaid#:_____

Name of Managed Care Company:_____ Effective Date: _____

PRIMARY INSURANCE INFORMATION:
Policy Holder's Name:_____ Relationship to Student:_____
Policy Holder's Address:_____ Policy Holder's DOB:_____
Policy Holder's Employer Name and Address:_____
InsuranceCarrierNameandAddress:_____
Member ID/Policy #:_____ Group #:_____ Effective Date of Coverage:_____
Policy Holder's Social Security #:_____ Insurance Phone #:_____

ADDITIONAL INSURANCE INFORMATION:
Policy Holder's Name:_____ Relationship to Student:_____
Policy Holder's Address:_____ Policy Holder's DOB:_____
Policy Holder's Employer Name and Address:_____
InsuranceCarrierNameandAddress:_____
Member ID/Policy #:_____ Group #:_____ Effective Date of Coverage:_____
Policy Holder's Social Security #:_____ Insurance Phone #:_____

I understand the purpose for this permission is to permit my child to obtain routine health services. These services may include mandated or sports physicals, the diagnosis and treatment of physical illnesses and conditions (using routine tests, treatments and medications), access to counseling services, prevention and health education. I further understand that I give permission to allow the School Based Health Center to share "as needed" information with my child's medical provider, the school nurse and key school personnel in order to effectively care for my child.

By my signature below, I give permission for the SBHC Nurse Practitioner to obtain the following information about my child from the school nurse: height(s) and weight(s), immunizations, screening results (vision, hearing, scoliosis, tuberculin skin tests), blood glucose and hemoglobin, information about allergies and chronic/acute illnesses or injuries, medications, demographic data and emergency numbers.

Furthermore, I give permission to the School Based Health Centers to release information regarding treatment and/or services to the above insurance providers for the purpose of billing. I authorize payments to be made directly to ***Child and Family Agency*** for services provided.

I have received Child & Family Agency's Notice of Privacy Practices printed on green paper that is included with this enrollment packet.

_____	_____	_____
Signature	**Relationship to Student**	**Date**

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE

USED, DISCLOSED, AND ACCESSED BY YOU.

Notice of Privacy Practices

Child and Family Agency of Southeastern Connecticut, Inc.

Effective Date: September 23, 2013 – updated June 14, 2016

It is important to read and understand this Notice before signing the Acknowledgement Form. If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the staff member working with you, his/her supervisor, or this Agency's Privacy Officer.

CFA Privacy Officer: Richard D. Calvert MSW, LCSW, CEO
Offices:
255 Hempstead Street, New London, CT 03620
860-443-2896

Child and Family Agency Administrative

255 Hempstead Street, New London, CT 06320
860-443-2896

Purpose of the Notice of Privacy Practices

This Notice of Privacy Practices (the "Notice") is meant to inform you of the ways we may use or disclose your protected health information. It also describes your rights to access and control your protected health information and certain obligations we have regarding the use and disclosure of your protected health information ("PHI").

Your protected health information (hereafter also referred to as "PHI") is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present, or future physical or mental health or condition, or payment for the provision of your health care. We are required by law to maintain the privacy of your PHI and you have the right to and will receive notification from us of a breach of your unsecured PHI, if such a breach occurs.

We are also required by law to provide you with this Notice of our legal duties and privacy practices with respect to your PHI and to abide by the terms of the Notice that is currently in effect. However, we may change our notice at any time. The new revised Notice will apply to all of your PHI maintained by us. You will not automatically receive a revised Notice. If you would like to receive a copy of any revised Notice, you should access our web site at http://www.childandfamilyagency.org, contact Child and Family Agency, or ask for a copy at your next appointment.

I. How We May Use or Disclose Your Protected Health Information

Child and Family Agency (also referred to hereafter as "CFA") will ask you to sign a consent form that allows CFA to use and disclose your protected health information. Even if not specifically listed below, CFA may use and disclose your PHI as permitted or required by law or as authorized by you. We will make reasonable efforts to limit access to your PHI to those persons or classes of persons, as appropriate, in our workforce who need access to carry out their duties. In addition, if required, we will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of any use or disclosure and to the extent such use or disclosure is limited by law. We may use and disclose your PHI for the following:

- **For Treatment** – to provide you with medical treatment and related services, including emergency situations. Your PHI may be used to refer you to other providers or to send your records to another treating health care professional. If we are permitted to do so, we may also disclose your PHI to individuals or facilities that will be involved with your care after you leave Child and Family Agency and for other treatment reasons.
- **For Payment** – so that we can bill and receive payment for the treatment and related services you receive. We may disclose your health information to your payment source, including insurance or managed care company, Medicare, Medicaid, or another third party payor. For example, we may need to give your health plan information to confirm your coverage, to request prior authorization for a proposed treatment, or to document the treatment you received so your health plan will reimburse us.
- **For Health Care Operations** –as necessary for operations of Child and Family Agency, such as quality assurance and improvement activities, reviewing the competence and qualifications of health care professionals, medical review, legal services, and auditing functions, and general administrative activities of

CFA. For example, we may use your health care information to work to improve the quality of the services we provide.

- **Business Associates** – There may be some services provided by our business associates, such as a billing service or legal or accounting consultants. We may disclose your PHI to our business associate so that they can perform the job we have asked them to do. To protect your health information, we require our business associated to enter into a written contract that requires them to appropriately safeguard your information.
- **Appointment Reminders** – unless otherwise instructed, to remind you that you of an appointment.
- **Treatment Alternatives and Other Health-Related Benefits and Services** – to tell you about or recommend possible treatment options or alternatives and to tell you about health related benefits, services, or medical education classes that may be of interest to you.
- **Individuals Involved in Your Care or Payment of Your Care** – Unless you object, we may disclose your PHI to a family member, a relative, a close friend or any other person you identify, if the information relates to the person's involvement in your health care to notify the person of your location or general condition or payment related to your health care. In addition, we may disclose your PHI to a public or private entity authorized by law to assist in a disaster relief effort. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment or if we reasonably infer that you would not object.
- **Public Health Activities** – to a public health authority that is authorized by law to collect or receive such information, such as for the purpose of preventing or controlling disease, injury, or disability; reporting births, deaths or other vital statistics; reporting child abuse or neglect; notifying individuals of recalls of products they may be using; notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health Oversight Activities** – to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation, licensure and disciplinary actions.
- **Judicial and Administrative Proceedings** – If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to your authorization or a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process if such disclosure is permitted by law.
- **Law Enforcement** – for certain law enforcement purposes if permitted or required by law. For example, to report gunshot wounds; to report emergencies or suspicious deaths; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.
- **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations** – to a coroner, medical examiner, funeral director, or, if you are an organ donor, to an organization involved in the donation of organs and tissues.
- **To Avert a Serious Threat to Health or Safety** – when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.
- **Military and National Security** – If required by law, if you are a member of the armed forces, we may use and disclose your PHI as required by military command authorities or the Department of Veteran Affairs. If required by law, we may disclose your PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by law. If required by law, we may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Workers' Compensation** – as permitted by laws relating to workers' compensation or related programs.
- **Special Rules Regarding Disclosure of Behavioral Health, Substance Abuse and HIV–Related Information** – For disclosures concerning protected health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special Authorization or a court orders the disclosure.
    - Behavioral health information. Certain behavioral health information may be disclosed for treatment, payment and health care operations as permitted or required by law. Otherwise, we will only disclose such information pursuant to an authorization, court order or as otherwise required by law. For example, all communications between you and a psychologist, psychiatrist, social worker and certain therapists and counselors will be privileged and confidential in accordance with State and Federal law.
    - Substance abuse treatment information. If you are treated in a specialized substance abuse program, the confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations.

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- Generally, we may not say to a person outside the program that you attend the program, or disclose any information identifying you as an individual being treated for drug or alcohol abuse, unless:
  1. You consent in writing;
  2. The disclosure is allowed by a court order; or
  3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these Federal laws and regulations by us is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the substance abuse program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under Stand law to appropriate State or local authorities.
- HIV–related information. We may disclose HIV–related information on as permitted or required by State law. For example, your HIV–related information, if any, may be disclosed without your authorization for treatment purposes, certain health oversight activities, pursuant to a court order, or in the event of certain exposures to HIV by personnel of CFA, another person, or a known partner (if certain conditions are met).
- Minors. We will comply with State law when using or disclosing PHI of minors. For example, if you are an unemancipated minor consenting to a health care service related to HIV/AIDS, venereal disease, abortion, outpatient mental health or alcohol/drug treatment, and you have not requested that another person be treated as a personal representative; you may have the authority to consent to the use and disclosure of your PHI.

II. When We May Not Use or Disclose Your Protected Health Information

Except as described in this Notice, or as permitted by State or Federal law, we will not use or disclose your PHI without your written authorization. Your written authorization will specify particular uses or disclosures that you choose to allow. Under certain limited circumstances, CFA may condition treatment on the provision of an authorization, such as for research related to treatment. If you do authorize us to use or disclose your PHI for reasons other than treatment, payment or health care operations you may revoke your authorization in writing at any time by contacting this Agency's Privacy Officer. If you revoke your authorization we will no longer use or disclose your PHI for the purposes covered by the authorization, except where we have already relied on the authorization.

Examples of Uses and Disclosures that Require Your Prior Authorization

- **Psychotherapy Notes** – A signed authorization is required for the use or disclosure of psychotherapy notes except for our own use to treat you, for our training programs and to defend ourselves in a legal action or other proceeding.
- **Marketing** – A signed authorization is required for the use or disclosure of your PHI for a purpose that encourages you to purchase or use a product or service except for certain limited circumstances (e.g. when the marketing communication is face-to-face or includes the distribution of a promotional gift of nominal value provided by CFA.
- **Sale of Protected Health Information** – Except when permitted by law, we will not sell your protected health information unless we receive a signed authorization from you.
- **Uses and Disclosures Not Described in this Notice** – Unless otherwise permitted by Federal or State law, other PHI uses and disclosures that are not described in this Notice will be made only with your signed authorization.

III. Your Health Information Rights

You have the following rights with respect to your PHI, which you may exercise as described:

- **Right to Request Restrictions of Your Protected Health Information** – You have the right to request certain restrictions or limitations on the PHI we use or disclose about you. You may request a restriction or revise a restriction on the use or disclosure of your PHI by providing a written request stating the specific restriction requested. You can obtain a Request for Restriction form from Child and Family Agency. You may require a restriction on disclosure of your PHI to a health plan (other than Medicare or other federal health care program that requires Child and Family Agency to submit information) and CFA must agree (unless otherwise required by law) to your request, if it is for purposes of payment or other health care operations (but not

treatment) if you paid out of pocket, in full, for the item or service to which the protected information pertains. Otherwise, we are not required to agree to your requested restriction. If or when we agree to accept your requested restriction, we will comply with your request except as needed to provide you with emergency treatment. If restricted PHI is disclosed to a health care provider for emergency treatment, we will request that such health care provider not further use or disclose the information. In addition, you and CFA may terminate the restriction (other than a restriction to a health plan for purposes of payment) if the other party is notified in writing of the termination. Unless you agree, the termination of the restriction is only effective with respect to PHI created or received after we have informed you of the termination**.**

- **Right to Receive Confidential Communications** – You have the right to request a reasonable accommodation regarding how you receive communications of PHI. You have the right to request an alternative means of communication or an alternative location where you would like to receive communications. You may submit a request in writing to Child and Family Agency requesting confidential communications. You can obtain a Request for Confidential Communications form from Child and Family Agency.
- **Right to Access, Inspect and Copy Your Protected Health Information** – You have the right to access, inspect and obtain a copy of your PHI that is used to make decisions about your care for as long as the PHI is maintained by Child and Family Agency. You also have the right to obtain an electronic copy of any of your PHI that we maintain in electronic format. You also have the right to request that CFA transmit a copy of your PHI directly to another person designated by you. To access, inspect and copy your PHI that may be used to make decisions about you, you must submit your request in writing to Child and Family Agency. If you request a copy of the information, we may charge a fee for the costs of preparing, copying, mailing or other supplies associated with your request. We may deny, in whole or in part your request to access, inspect and copy your PHI under certain limited circumstances. If we deny your request, we will provide you with a written explanation of the reason for the denial. You may have the right to have this denial reviewed by an independent health care professional designated by us to act as a reviewing official. This individual will not have participated in the original decision to deny your request. You may also have the right to request a review of our denial of access through a court of law. All requirements, court costs and attorney's fees associated with a review of denial by a court are your responsibility. You should seek legal advice if you are interested in pursuing such rights.
- **Right to Amend Your Protected Health Information** – You have the right to request an amendment to your PHI for as long as the information is maintained by or for Child and Family Agency. Your request must be made in writing to CFA and must state the reason for the requested amendment. You can obtain a Request for Amendment form from CFA. If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial. We may rebut your statement of disagreement. If you do not wish to submit a written statement disagreeing with the denial, you may request that your request for amendment and your denial be disclosed with any future disclosure of your relevant information.
- **Right to Receive an Accounting of Disclosures of Protected Health Information** – You have the right to request an accounting of certain disclosures of your PHI by this Agency or by others on our behalf. We are not required to account for all disclosures, including disclosure for treatment, payment or health care operations. However, effective January 1, 2014, if we have made any disclosures for treatment, payment or operations through an electronic health record, we are required to include those disclosures that occurred with three (3) years of the date of your request. To request an accounting of disclosures, you must submit a request in writing, stating a time period beginning on or after April 14, 2003 that is within six (6) years (or on or after January 1, 2014 that is with three (3) years for disclosures of PHI through an electronic health record) from the date of your request. We may charge you a reasonable, cost-based fee for each future request for an accounting within a single twelve-month period. However, you will be given the opportunity to withdraw or modify your request in order to avoid or reduce the fee. Please note that, at times, companies we work with (called "business associates") may have access to your PHI. When you request an accounting of disclosures from CFA, we may provide you with the accounting of disclosures or the names and contact information of our business associates, so that you may then contact them directly for an accounting.
- **Right to Obtain a Paper Copy of Notice** – You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting Child and Family Agency. In addition, you may obtain a copy of this Notice at our web site www.childandfamilyagency.org.

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- **Right to Request Transmission of Your Protected Health Information in Electronic Format** – You may direct us to transmit an electronic copy of your PHI in electronic format to an individual or entity you designate. To request the transmission or your electronic health information, you must submit the request in writing to CFA.
- **Right to Complain** – You may file a complaint with us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us through our Privacy Officer, for which you will not be penalized. We will make every reasonable effort to resolve your complaint with you.
- **Right to be Notified of a Breach –** You have the right to be notified in the event of a breach of the privacy or security of your protected health information.
- **Right to Revoke** – CFA will comply with a written request of an individual to revoke an authorization.

PLEASE RETURN AII COMPLETED FORMS

HEALTH HISTORY

NOTE: Please complete the following information. This will be very helpful to the School Based Health Center providers and will be kept confidential as stated in our HIPPA Policy. Please return this form with the registration forms.

Name of Student: **Date of Birth:** **School:**

Does your child have any of the following conditions?

ADD/ADHD	❑ Yes	❑ No		Heart disease	❑ Yes	❑ No	
Anemia	❑ Yes	❑ No		Hypertension	❑ Yes	❑ No	
Asthma	❑ Yes	❑ No		Immune disorder	❑ Yes	❑ No	
Birth defects	❑ Yes	❑ No		Learning difficulties	❑ Yes	❑ No	
Bipolar	❑ Yes	❑ No		Overweight	❑ Yes	❑ No	
Cancer	❑ Yes	❑ No		Seizures	❑ Yes	❑ No	
Diabetes	❑ Yes	❑ No		Substance Abuse	❑ Yes	❑ No	
Dental problems	❑ Yes	❑ No		Tobacco Use	❑ Yes	❑ No	
Depression	❑ Yes	❑ No		Thyroid disease	❑ Yes	❑ No	
Eczema	❑ Yes	❑ No		Tuberculosis	❑ Yes	❑ No	
Head injury	❑ Yes	❑ No	For girls:	Menstrual problems	❑ Yes	❑ No	

Any other conditions or concerns? _____

Has your child been in the hospital overnight?	❑ Yes	❑ No	When:_____	Why:
Has your child had surgery?	❑ Yes	❑ No	When:_____	Why:
Has your child been in a serious accident?	❑ Yes	❑ No	When:_____	Type:
Is your child allergic to any medicine?	❑ Yes	❑ No	Name of medicine:	
Is your child allergic to any food or other things?	❑ Yes	❑ No	Name of food/other:	
Has your child had chicken pox?	❑ Yes	❑ No	At what age?	
Does your child take any medicines?	❑ Yes	❑ No	For what?	
Does your child take any vitamins or supplements?	❑ Yes	❑ No		
Please list any medications/vitamins/supplements:				
Is your child receiving any counseling at this time?	❑ Yes	❑ No	Where?	
Has your child been in counseling in the past?	❑ Yes	❑ No	Where?	
Does your child have a regular primary care provider?	❑ Yes	❑ No	Name:	
If not, where does your child get medical care?	☐	☐		

FAMILY HISTORY Does anyone in the child's family, including grandparents have the following conditions?

			Which relative?				Which relative?
ADD/ADHD	❑ Yes	❑ No	☐	Heart disease	❑ Yes	❑ No	
Anemia	❑ Yes	❑ No	☐	Hypertension	❑ Yes	❑ No	
Asthma	❑ Yes	❑ No	☐	Immune disorder	❑ Yes	❑ No	
Birth defects	❑ Yes	❑ No	☐	Learning difficulties	❑ Yes	❑ No	
Bipolar	❑ Yes	❑ No	☐	Overweight	❑ Yes	❑ No	
Cancer	❑ Yes	❑ No	☐	Seizures	❑ Yes	❑ No	
Diabetes	❑ Yes	❑ No	☐	Substance Abuse	❑ Yes	❑ No	
Dental problems	❑ Yes	❑ No	☐	Tobacco Use	❑ Yes	❑ No	
Depression	❑ Yes	❑ No	☐	Thyroid disease	❑ Yes	❑ No	
Eczema	❑ Yes	❑ No	☐	Tuberculosis	❑ Yes	❑ No	
Head injury	❑ Yes	❑ No	☐	Menstrual problems	❑ Yes	❑ No	

Parent/Guardian Signature: _____ Date: _____

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CONNECTICUT VACCINE PROGRAM

Patient Eligibility Screening Record

Date Screened: _____

Child's Name: _____

Date of Birth: _____

Parent/Guardian _____

Provider: _____

This child qualifies for immunization through the Connecticut Vaccine Program since he/she (check only one box):

VFC eligible:

(A) Is enrolled in Medicaid (HUSKY A) ☐

(B) Has no health insurance/self pay ☐

(C) Is American Indian or Alaskan Native ☐

(D) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a Federally Qualified Health Center (FQHC). These patients can receive all vaccines at their FQHC.

State eligible:

(E) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a private health care provider. ☐

These patients can receive all vaccines at their private health care provider's office.

(F) Is enrolled in S-CHIP (HUSKY B) ☐

(G) *Is Privately Insured ☐

*Note private insurance patients can receive all vaccines from the Connecticut Vaccine Program except for Pneumococcal Conjugate, Rotavirus, Human Papillomavirus vaccine (HPV), Influenza for 5-18 year olds, and Hepatitis A for 2-18 year olds which are only available for patients in categories A, B, C, D, E & F.

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age and younger who receive vaccine from the Connecticut Vaccine Program. The record may be completed by the parent, guardian, or individual of record, or by the healthcare provider. The record does not have to be updated unless the status of the child has changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PLEASE RETURN All COMPLETED FORMS