SBHC Location: Highland ES

Montgomery County Department of Health and Human Services
Linkages to Learning School Based Health Center

Enrollment Form

Please complete both sides of form Student ID #

Child's Name ____________ Home School ____________ Grade ____

Birthdate ____________ Social Security # ___-__-____ Gender ____ Race ____________

Address ____________ Home Phone ____________

City ____________ Stat ____________ Zip Code ____________

Country of Birth ____________ Primary Language ____________

Parent/Guardian ____________ Work Phone ____________

Non Parent Emergency Contact ____________

Contact's Relationship to Child ____________ Contact's Phone ____________

I grant permission for my child, ____________, to enroll in the *Linkages to Learning* School Based Health Center. I consent to his/her receiving services which may include complete physical examinations, treatment for chronic and acute health problems, limited diagnostic tests, dental evaluation, health education, case management and /or referrals to *Linkages to Learning* mental health and social services.

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the School Based Health Center.
- All School Based Health Center records are confidential and only the School Based Health Center staff and providers will have access to a child's School Based Health Center records and information.
- Services at the School Based Health Center will be provided by staff employed by or contractors with Montgomery County Department of Health and Human Services.
- I authorize the release of any medical or other information necessary to process insurance claims, if applicable and authorize payment of the medical benefits to Montgomery County for services rendered in the School Based Health Center.

I understand the description of services and policies of the School Based Health Center as stated above and give permission for my child to enroll and receive services in the *Linkages to Learning* School Based Health Center. I understand that this permission can be withdrawn at any time by submitting notice in writing.

Signature of Parent/Legal Guardian ____________ Date ____________

Print Name ____________ Relationship to Student ____________

SBHC Location: ___________________________

Montgomery County Department of Health and Human Services
Linkages to Learning School Based Health Center

Health Insurance Information

Child's Name:_______________________ Birthdate:__________ Home School:________________

Please complete one of the boxes below. Please provide a copy of your insurance card, if available.

Your insurance company may be billed. Parent/Guardian(s) will not be billed.

☐ **My child has no health care coverage / health insurance.**

☐ **My child is enrolled in Care For Kids.**

☐ **My child has Medical Assistance. Please complete the following information:**

Child's Medical Assistance Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Child's Managed Care Organization_______________________________
(If you have not selected a MCO, write "none")

Name of Child's Doctor_______________________________

Doctor's Telephone Number_______________________________

☐ **My child has private health insurance. Please complete the following information:**

Name of Policy Holder _______________________________

Relationship to Child _______________________________

Social Security Number of Policy Holder _______________________________

Policy Holder's Place of Employment _______________________________

Name of Insurance Company _______________________________

Address of Insurance Company_______________________________ Zip Code_______

Insurance Company Telephone Number _______________________

Group Number ____________________ Policy Number ____________________

Child's Doctor ____________________ Telephone Number ____________________

*** No child will be denied services because of inability to pay. ***

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE!

SCHOOL BASED HEALTH and WELLNESS CENTER

Consent to Administer Over the Counter Medications to Enrolled Students

The medications listed below are stocked at the School Based Health and Wellness Centers. If your child is **enrolled** for services, he/she may be given one of these medications, if in the judgment of the school nurse or nurse practitioner they might be helpful. You will be notified by telephone or by note, if and when your child is given of these medications.

To give your permission for your child to take any of these medications, please check **YES** below. If you do not want your child to receive one or more of these medications, check **NO.**

ASPIRIN SUBSTITUTE (acetaminophen {Tylenol}) ____YES ____NO
-For fever greater than 100° and/or discomfort/pain.

ANTIHISTAMINE (chlorheniramine maleate) ____YES ____NO
-for allergic reaction and/or nasal congestion.

ANTIHISTAMINE (diphenhydramine hydrochloride {Benadryl}) ____YES ____NO
-for allergic reaction and/or nasal congestion.

Child's Name________________________ **DOB**___/___/___ **Grade**_____

Parent/Guardian Signature________________________ **Date**___/___/___

SBHWC 308-1A 08/10

SCHOOL BASED HEALTH AND WELLNESS CENTER
STUDENT HEALTH HISTORY

Patient Name:		Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: ______________________
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: ______________________
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight__________ Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:__________
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?______________________
____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?______________________
Date of Birth? Mother__________
Father__________
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? ________ Dates:__________
Other Languages?______________________

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) __________	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention Deficit Disorder	No ☐	Yes ☐	_____
	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: ______________________
____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) __________	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: __________	No ☐	Yes ☐

Current Medication(s): (*List*) ______________________
____

Reviewed by:	Date of Review:

Montgomery County Department of Health and Human Services

Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?

We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?

Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice*.

Contact Information:

If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 3050. Additional contact information is provided at the end of the *Notice*.

Acknowledgement of receipt of the complete *Notice*:

____ _______________

Client or Authorized Representative (Sign your name) Date

____

Print your name

________________________ ____________________________________

Signature of DHHS representative Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: ______________________________

MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH AND OTHER PERSONAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Our Services and Information We Collect

The Montgomery County Department of Health and Human Services (DHHS) is a large, multi-service agency that provides health, mental health, substance abuse, child welfare, income support and other social services. To provide you with services, DHHS staff will ask you for personal information that they will keep in your records. This information may include:

- Information that identifies you, such as your name, address, telephone number, date of birth and social security number.
- Financial information, which includes information about your income, your bank accounts or other assets, and any insurance coverage that you have.
- Protected health information, which includes any information that tells us about your past, present or future health or mental health treatment.
- Information about benefits or services that you are receiving or have received.

Our Responsibilities

Federal and State laws protect the privacy of your health and other personal information and we will follow all of those laws. We will take reasonable steps to keep your information safe, and will use (share within DHHS) and disclose (share with persons outside of DHHS) your information only as necessary to do our jobs and as permitted or required by law.

If we have a need to use or disclose your information for any reason other than those listed below, we will ask you for your written permission. You have a right to cancel any written permissions you have given to us. If you cancel your permission, the cancellation will not apply to uses and disclosures that we have already made based on your permission.

We are required by law to provide you with this *Notice of Privacy Practices* and to follow it. We have the right to change our privacy practices and the terms of this *Notice* and to make the changes effective for all health and other personal information we maintain. We will let you know about any changes to our privacy practices at your next visit to our offices. A current version of our *Notice* will be available in our waiting rooms and on the DHHS website at www.montgomerycountymd.gov

How We May Use and Disclose Information *without* your Written Permission

- **For Treatment and Services:**
  DHHS staff who work with you may use your health and other personal information as necessary to provide you with coordinated treatment and services. Examples:

- If you are receiving health care from one of our clinics and want to apply for other services such as housing assistance or income supports, your case worker can help you access those services by making referrals and sharing eligibility information.
- If you are receiving more than one DHHS service, your case workers may communicate with one another to develop a coordinated service plan with you when appropriate.

DHHS staff in the following programs will not share program information about you with staff who are providing you with services in other programs without your written permission:

- Alcohol and Substance Abuse Treatment Programs
- Domestic Abuse, Sexual Assault or Victim's Assistance Programs
- DHHS programs that maintain records that are considered "education records" under the Family Education Rights and Privacy Act of 1974.

DHHS staff will share your information with persons *outside* of our DHHS agency for treatment or services only with your written permission or as allowed by federal or State law. For example, federal and State laws permit our DHHS staff that provide you with health care to share your health information with outside health care providers who are also treating you.

- **For payment**: We may use or disclose health and other personal information about you as necessary to obtain payment for the health and mental health services you receive. For example, we may use your information to bill Medicaid or Medicare for treatment you received

- **For Health Care/Business Operations**: We may use or disclose your health and other personal information to manage our programs or activities. For example, DHHS staff or outside auditors may look at your case record to review the quality of services that you receive through our department.

- **For Appointments or Notifications**: We may need to contact you or your representative, to schedule or remind you of an appointment, to ask you to complete paperwork, to inform you about other related benefits or services that you may be interested in, or to reach you in an emergency.

- **To our Business Associates**: We have agreements with persons outside of DHHS to provide us with administrative and support services, such as financial or legal services, data analysis, and accreditation and quality assurance reviews. These persons are called business associates. We may disclose your information to business associates so that they can perform these services for us. However, we require our business associates to keep your information safeguarded.

- **To your Family, Friends and Others Involved in Your Care**: We may disclose your health information to your family or others who are involved in your medical care. For example, we may discuss your medical condition with your adult daughter or son who is arranging for your care at home. If you do not want us to share this information with your family, you can ask that we not do so. We will not share information about your mental health or substance abuse history or care with your family unless you give us written permission.

- **For Government Programs**: We may disclose health and other personal information about you to determine if you are eligible for other government benefits or programs such as Social Security benefits.

- **For Public Health Activities:** We may use or disclose health information about you for public health activities. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of this disease.

- **For Abuse and Neglect Reports and Investigations:** We are required by law to report any cases of suspected abuse or neglect of children or vulnerable adults, including adults abused as children.

- **To Avoid Harm:** DHHS may disclose health and other personal information about you to law enforcement under certain conditions. For example, if you harm a member of our staff or another client, if you damage our property or if our professional staff believes that you are likely to cause serious harm to others or yourself, we will contact law enforcement. DHHS may also disclose your health and other personal information in case of a threat to the public, such as a terrorist attack or emergency disaster.

- **To Coroners, Funeral Directors, Medical Examiners and for Organ Donation:** DHHS may disclose health information relating to death to coroners, medical examiners and funeral directors and also to authorized organizations relating to organ, eye or tissue donations or transplants.

- **For Research Purposes:** We may use or disclose your health information for medical research purposes under certain circumstances. In some cases, your written permission will be needed. Research studies and reports will not identify people by name.

- **For Court proceedings:** We may be required by law or court order to provide information about you to the court.

- **As Required by Law:** If a law or regulation requires that we disclose your health or other personal information, we must do so.

How We May Use or Disclose Alcohol or Substance Abuse Program Information

The confidentiality of alcohol and drug abuse treatment records is protected by federal law and regulations. Generally, we will not use or disclose information related to your alcohol or drug abuse treatment unless:

- You have given us your written permission;
- The disclosure is allowed by Court order;
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Your Rights Regarding your Information

You have the right to:

- Obtain a copy of this Notice of Privacy Practices. This notice is available in alternative format upon request.
- Ask us to contact you at a different location or to contact you by a different method than we routinely use. For example, you may ask that we contact you by phone or mail at work instead of at home.
- See, review and receive a copy of information we maintain about you. *You must make this request in writing* and you may be charged a fee to pay for the cost of copying your record. There are certain situations when we may not give you the right to review or obtain a copy of

your records. If this happens, we will explain why we made this decision and how you can ask for a review of the denial or file a complaint.

- Make a request that your information be amended (changed) if you feel the information we have is wrong or incomplete. *You must do this in writing.* In some situations, we are not required to make the change. If we do not agree to make the change, we will explain why and inform you about your right to give us a written statement disagreeing with the denial.
- Receive an accounting (a detailed listing) of disclosures we have made of your health information after April 14, 2003. This listing will not include disclosures made for treatment, payment or health care operations purposes, or disclosures you have permitted us to make. *You must make this request in writing.*
- Request that we not share health information with a family member or others involved in your care.
- Request that we not use or disclose your information for a treatment/service, payment or health care operations purpose. *These requests must be made in writing.* We are not required to agree to these requests, but if we do, we must comply with the agreement, unless we need to disclose the information for your emergency treatment. If we cannot agree to your request, we will explain why.
- To file a complaint or report a problem.

How to Make a Request

If you have questions about our privacy practices or want to make a request for any of the above, contact the staff person who is working with you, or our Privacy Official at the address listed at the end of this notice. We ask that you use the *DHHS Client Request Form* for requests that must be made in writing. You can obtain the form from any DHHS office or by contacting our Privacy Officer.

To File a Complaint or Report a Problem

To file a complaint or report a problem about how we have used or disclosed information about you, contact our Privacy Officer at the following address:

Privacy Officer
Montgomery County Department of Health and Human Services
401 Hungerford Drive
Rockville, MD 20850
240-777-3050 (Voice) 240-777-1398 (TTY)

We will not take any action against you for filing a complaint or for cooperating with an investigation, and the benefits and services you receive will not be negatively affected in any way.

If your complaint or concerns relate to how we have used or disclosed your *health* information, you may also contact:

Region III, Office for Civil Rights, U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372
Public Ledger Building, Philadelphia, PA 19106-9111
215-861-4441 (voice) 215-861-4441 (TDD) 1-800 368-1019 (Hotline)