School-Based Health Center Enrollment Packet

If you would like your child to receive services at their school-based health center, please complete the attached enrollment packet.

Services offered include:

*Physical/Well Child Exams *Treatment of Illness & Injury *Prescriptions *Lab Tests *Sports Physicals
*Chronic Illness Management *Immunizations/Vaccines *Mental Health Counseling *Dental Services

Frequently asked questions about SBHCs:

- ✓ SBHCs increase access to health care and decrease missed school time for students with consent on file.
- ✓ If you have a family doctor, you can still use the SBHC.
- ✓ Our services are convenient if your child gets sick or injured at school.
- ✓ Parents are welcome to call the SBHC staff with questions and accompany children to their appointment.
- ✓ This consent is valid if your child moves to another school with a NRH SBHC, unless you direct us otherwise.
- ✓ NRH will bill private insurance, Medicaid and CHIP for eligible students.
- ✓ No child will be denied services due to inability to pay.
- ✓ A separate consent form will be sent home for parent/guardian signature before vaccines are given.
- ✓ NRH provides after-hours phone call coverage seven days a week.
- ✓ Call 304-469-2905 after hours with any health-related concerns.

School Based Health Center Locations

Coal City Elementary – 304-683-6904
Fayetteville PK-8 – 304-900-5262
Independence High – 304-683-6905
Independence Middle – 681-539-3337
New River Intermediate – 304-465-2171
New River Primary/OHMS – 304-900-5255
Oak Hill High – 304-469-6331
Summersville SBHC – 304-883-3900
Valley PK-8 – 304-981-4983

To complete the form electronically scan this code with your cell phone to take you to the link.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibility.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record ~You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record ~You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications ~You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests and do our best to honor your preferred method of contact.

Ask us to limit what we use or share ~You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. ~~If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of this privacy notice ~You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you ~If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ~We will make sure the person has this authority and can act- for you before we take any action.

File a complaint if you fee] your rights are violated ~You can complain if you feel we have violated your rights by contacting us using the information at the end of this Notice. ~You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.~We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

~Share information with your family, close friends, or others involved in your care

~Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

~Marketing purposes ~Sale of your information ~Most sharing of psychotherapy notes ~

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. *Example:* A doc- tor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health in- formation to run our practice, improve your care, and contact you when necessary. *Example:* We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. *Example:* We give information about you to your health insurance plan so it will pay for your services.

Other ways we use or share your health information: We are allowed or required to share your information in other ways usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy /hipaa/understanding/consumers/ index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research**.**

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions ~We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibility

~We are required by law to maintain the privacy and security of your protected health information.

~We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

~We must follow the duties and privacy practices described in this notice and give you a copy of it.

~We will not use or share your information other than as de- scribed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Information:

You may contact us for further information or make any com- plaints about the privacy of your health information at: Lori Watkins, New River Health PO Box 337 Scarbro, WV 25907 Telephone: 304-469-2905

Our organization provides integrated primary care and behavioral health services and our healthcare providers share information about your care internally among your care team members and externally with other providers involved in your care unless a law or regulation limits this without your authorization (we may ask for this to better coordinate your care). Any refusal to give authorization for sharing information will in no way jeopardize your right to obtain present or future treatment except as otherwise provided by law.

Certain West Virginia laws provide more safeguards for health information than federal law. We will abide by these more stringent restrictions which require (subject to certain exceptions): either your written authorization or a court order, for disclosure of information about your mental health care or about HIV or AIDS testing of you (as defined by WV law); that before performing an abortion for a minor, a physician intending to perform the abortion must notify the minor's parent or legal guardian if they can be found, but, under some circumstances, a minor may get a court order forbidding such disclosure; a physician may, at the request of a minor patient, withhold from the patient's parents or legal guardian information about venereal disease treatment, birth control, pre- natal care, or drug rehabilitation treatment of the minor; or a physician may, at the request of a minor patient whom the physician believes to be a "mature minor" capable of making his or her own health care decisions, withhold medical information about the minor from the minor's parents or legal guardian and may follow the minor's instructions about disclosure or non- disclosure of the mature minor's medical information.

Effective Date of this Notice: July 20, 2021

This Notice applies to all facilities operated by New River Health Association, Inc.

STUDENT/PATIENT INFORMATION

Name of Child:	Date of Birth:	Social Security Number:		
Mailing Address:	**City:**	**State:**	**Zip Code:**	**Child's Grade:**

☐ Male ☐ Female	☐ Non-Hispanic ☐ Hispanic/Latino	☐ White ☐ Asian ☐ Black ☐ Other	Child's School:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:	Relationship to Child:	Date of Birth:	Social Security Number:
Cell Phone Number:	**Home Phone Number:**	**Work Phone Number:**	**Child's Cell Phone Number:**

List any individual below other than yourself we can contact about medical care in case we can't reach you.

Name	Relationship to Child	Cell Phone Number	Home Phone Number

STUDENT/PATIENT HEALTH INFORMATION

List allergies:	Allergic to any Medications, please list and reaction:
Current prescription medications:	**Current nonprescription medications:**
Sports related injuries or concussions: **Yes ☐ No ☐**	**If yes, please explain:**
Child's medical provider:	**Date of last well-child exam:**
Child's dentist:	**Date of last dental visit:**
Has child received mental health counseling: **Yes ☐ No ☐**	**If yes, name of mental health provider:**
Smokers in your home: Yes ☐ No ☐	**Vaping in the home: Yes ☐ No ☐**
Any hospitalizations: Yes ☐ No ☐	**Please list reason & date:**
Preferred pharmacy:	**Pharmacy location:**

Child lives with (please circle all that apply):

Mother Father Sisters Brothers Stepfamily Grandparents Other Relatives Foster Care

Please check any of the following conditions that your child has:

__Abuse/Neglect __Constipation __Enuresis (bedwetting) __Hearing Loss __Speech Disorders
__Congenital Heart Disease __Developmental Disorders __Eyesight Disorders __Otitis Media __Urinary Tract Infections
__Congenital Malformation __Drug Related Disorders __Fractures __Preterm Infant __Other: _____

Please check any prior surgeries for your child:

__Adenoidectomy __Inguinal Hernia Repair __Orchiopexy __Other (please explain) _____
__Appendectomy __Myringotomy (tubes) __Tonsillectomy _____
__Gastrostomy __Nissen Fundoplication __Umbilical Hernia Repair

In the past year, have there been any changes in your family (check all that apply): ☐ Birth ☐ Death ☐ Divorce ☐ Family incarceration ☐ Foster Care ☐ Loss of job ☐ Marriage ☐ Moved ☐ Separation ☐ Serious illness ☐ Other:

Would you like us to do a well child exam during the school year?	Yes ☐ No ☐
Does your child have any disabilities? Please list:	Yes ☐ No ☐

Family History: Check all that apply.	Child	Mom	Dad	Maternal GM/GF	Paternal GM/GF	Siblings
ADD/ADHD						
Allergies						
Anemia						
Asthma						
Autism Spectrum Disorder						
Birth Defect						
Blood Disorder						
Cancer						
Cerebral Palsy						
Congenital Abnormalities						
Coronary Artery Disease						
Diabetes						
Eczema						
Epilepsy/Seizures						
Gastrointestinal Disorders						
Heart Disease						
Hyperlipidemia						
Hypertension						
Immune/Autoimmune Disorder						
Intellectual Disability						
Kidney Disease						
Mental Illness						
Migraines/Headaches						
Substance Abuse						
Thyroid Disorder						
Tuberculosis						

INSURANCE INFORMATION

My child has Medicaid or CHIP insurance? Check your child's Medicaid Carrier.

☐ Aetna Medicaid ☐ CHIP ☐ Molina MCD ☐ The Health Plan Medicaid ☐ Unicare Medicaid

MCD ID# _____ CHIP ID#: _____

My child has Private insurance: Yes ☐ No ☐ Insurance Name: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ Social Security # _____

Insurance Address: _____

My Child doesn't have insurance: ☐ **Contact our office for information on insurance plans you may qualify for.**

PARENTAL CONSENT

The above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illnesses, prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child. I, the parent/guardian of said child, give consent for my child to receive services by New River Health School-Based Health Center staff. I understand that giving consent for my child to receive services may include nursing care, medical treatment (including dispensing of over-the-counter meds), and referral for counseling. I understand that this consent will be valid until I provide the health center staff with written directions otherwise. If your child changes schools, this consent will be valid at all NRH school health sites unless you advise us otherwise.

All healthcare information is confidential. By signing the consent below, you are giving the NRH SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. By signing below, you are giving permission for NRH staff to photograph your child to be used for their Electronic Medical Record. The health center may release information regarding treatment to third party payors for billing purposes.

Child's Name:	**Date of Birth:**

***Parent/Guardian Signature for SBHC services:**	**Relationship to Child:**	**Date:**
By signing I am acknowledging that I have received a copy of the NRH attached Notice of Privacy Practices.	***Privacy Practices Signature:**	**Date:**

*Signature required for services

DENTAL CONSENT

New River Health will offer preventive dental services at your child's school including dental X-rays, cleanings, fluoride, sealants, and exams by licensed dentists and hygienists. If your child needs further treatment, such as fillings, extractions or orthodontics, information will be sent t on how to obtain these services. If you would like your child to take advantage of the dental services offered in the school-based health centers, please read this form carefully, complete the questions and sign.

Only complete the information below if you would like your child to receive dental services at their school-based health center.

☐ **Yes** - I would like for my child to receive dental services **(exams, sealants, fluoride, cleanings, x-rays)** at their school-based health center and understand that my child may be referred to a local dentist for further treatment.

Child's Name:	**Date of Birth:**	***Parent/Guardian Signature for Dental Service:**	**Date:**

List any food allergies:	**Allergic to any Medications? Please list and reaction:**	
Current prescription medications:	**Current nonprescription medications:**	
Does your child have a dentist? Yes ☐ No ☐	**Name of dentist:**	**Date of last visit?**

Does your child have any of the following conditions? (Mark all that apply): ☐ Requires Pre-Med Antibiotics
☐ Blood Disorders ☐ Autism ☐ ADHD ☐ Seizures ☐ Heart Murmur ☐ Congenital Heart Disease
☐ Artificial Heart Valves ☐ Diabetes ☐ Other Conditions not listed: _____

Surgeries your child has had in the last five years.	**Please list dates for each surgery:**

My child has Medicaid or CHIP dental insurance? Check your child's Medicaid Carrier.

☐ Aetna Medicaid ☐ CHIP ☐ Molina MCD ☐ The Health Plan Medicaid ☐ Unicare Medicaid

MCD ID# _____ CHIP ID#: _____

My child has Private Dental Insurance: Yes ☐ No ☐ Insurance Name: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ Social Security # _____

Insurance Address: _____

My Child doesn't have insurance: ☐ Contact our office for information on insurance plans you may qualify for.

After completing this enrollment packet, please return to your child's teacher or health center.

You can also complete vaccine consents online that your child may need. If your child could benefit from counseling services, our referral form can be found online as well. The link to our online forms is newriverhealthwv.com/sbh or scan the code below to take you to our school health website.

New River HEALTH