Choptank Community Health System
Caroline County School Based Health Centers
Healthy Children Are Better Learners
MEDICAL

Dear Parent/Guardian:

As a student in the Caroline County Public School system, your child has access to the **Choptank Community Health System School Based Health Centers**. The mission of the Centers is to **improve the health of students and faculty**, **increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source** of **quality health care** staffed by nurse practitioners, dental hygienists and licensed counselors that work in collaboration with your child's doctor and the school nurse. Your child can receive medical and dental treatment right at school! There is no need to take time off from work to take your child to the doctor and/or travel to/from school, home and a doctor's office given the high price of gasoline.

Services: Treatment for minor health issues/injuries, assistance in managing chronic illnesses, prescriptions, health assessments, routine lab/diagnostic tests, health education, referrals to specialists and sports physicals. Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report on the visit is shared with your child's primary doctor.

Cost: Federal and state regulations require all providers, including Choptank Community Health System (CCHS), to bill all patients for School Based Health Center program services. The Medicaid programs cover School Based Health Center charges. If your child has health insurance, we will bill the insurance company for health services and follow the billing requirements associated with your plan. Depending on your insurance plan, you may receive a bill from CCHS for copays, unmet deductibles and any non covered services. If CCHS is not a participating provider with your insurance plan, you will be billed directly for services. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their income. All patients are eligible to apply for the sliding fee program even if they have insurance. Finally, the cost associated with lab services will be billed to your insurance. Bills for these tests will come directly from the lab company.

Enrollment: All Caroline County Public School students can enroll in the program. Please complete the attached Enrollment, Release of Information and Health History forms. Return them to the school nurse or the Health Center. Once your child is enrolled in the Health Center, they will not need to re-enroll each year. If you have any questions about the program, please contact CCHS at (410) 479-4306, ext 5012.

Choptank Community Health System, Inc. Notice of Privacy Practices
Effective April 14, 2003

This Notice of Privacy Practices describes the personal information we collect, how and when we may use or disclose this information. It also describes your rights and our responsibilities related to your protected health information.

How will CCHS use your Protected Health Information?

1. We will use your health information for **treatment**. Information obtained by the staff will be recorded in your medical record and used to determine the course of treatment that should work best for you.
2. We will use your health information for **payment**. A bill may be sent to you or your insurance company. The information on or with the bill may include information that identifies you as well as your diagnosis, procedures and supplies used during your visit.
3. We will use your health information for regular health **operations**. Members of the quality improvement team may use information from your health record to assess the care and outcomes in your case and others like it. This information may then be used as we strive to continually improve the quality and effectiveness of the health care we provide.

Additional ways we may use your health information:

1. There are some services provided in our organization through contracts with business associates. We may disclose your health information to them.
2. Unless you notify us that you object, we may use your name for directory purposes.
3. We may disclose information to notify a family member, a personal representative or another person responsible for your care of your location and general condition.
4. We may disclose your information for research purposes when researchers have established protocols to ensure your privacy.
5. We may disclose information to organ procurement organizations for the purposes of tissue donation or transplant or to funeral homes.
6. We may contact you to provide appointment reminders or information about treatment alternatives for you.
7. We may contact you as part of a fundraising effort.
8. We may use your information to enable product recall, repairs or replacement.
9. We may use your information to comply with laws such as workers compensation or similar programs.
10. We may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury or disabilities.
11. We may disclose your information to correctional institutes of for law enforcement.

Your health information rights:

- Obtain a copy of this notice.
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of the disclosures of your health information.
- Request communications of your health information by alternative means.
- Request a restriction on certain uses and disclosure of the information.
- Revoke your authorization to use or disclose your health information.

CCHS is required to:

- Maintain the privacy of your health information.
- Provide you with this notice describing our legal duties and privacy practices.
- Abide by this agreement.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means.

CCHS reserves the right to change our practices and to make the new provisions effective for all the protected health information we maintain. Should our privacy practices change, we will provide you with a copy of the revised notice. We will not disclose or use your health information without your authorization (except as described in this notice). We will also discontinue to use or disclose your health information after we receive your written request.

For more information or to report a problem, contact the CCHS Privacy Officer at 410-479-4306. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, NE, Room 509 F, HHH Building, Washington DC, 20201. There will not be retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

Choptank Community Health System
Caroline County School Based Health Program Enrollment Form
My child is a student at:

My child is a student at:

☐ Federalsburg Head Start ☐ Greensboro Head Start ☐ Ridgely Elementary
☐ Federalsburg Elementary ☐ Greensboro Elementary ☐ Denton Elementary ☐ Colonel Richardson Middle
☐ Lockerman Middle ☐ North Caroline High ☐ Preston Elementary ☐ Colonel Richardson High

Student's name _____ _____ _____
Last First Middle

Home address _____
Street City State/Zip

Phone_____ Social Security# _____ ☐ Male ☐Female

Date of Birth _____ Race _____ Hispanic/Latino? ☐ Yes ☐ No

Grade _____ Homeroom _____

Parent/legal guardian name _____

Relationship to student _____

Address (if different than student) _____

Phone: Home _____ Work _____ Cell _____

In case of emergency call:

Name _____ Phone _____

Name _____ Phone _____

Does your child have health insurance?
☐ NO, please send a sliding fee program application.
☐ YES, please complete the following:
Name of insurance company _____

Policy/Medical Assistance # _____ **Group #** _____

Insurance billing address _____

Policy holder name _____ **Policy holder DOB** _____
Does your child have a Doctor/Primary Healthcare provider? ☐ Yes ☐ No

Name of Doctor/Primary Healthcare provider _____

Address _____ **Phone #** _____
Name of Dentist _____ **Phone #** _____
Pharmacy _____

I understand that my signature gives consent for the CCHS School Based Health Center Providers to treat my child and to communicate with my child's primary health care provider. I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. CCHS may also mail healthcare information to my home. I understand the student may request that visits remain confidential. Maryland Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, or contraception. Students age 16 and over may receive mental health services without parental consent. I understand that my child's health information will be used for treatment, payment and health care operations. I recognize that school records may be used to obtain information left blank on the enrollment form. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. If I do not have insurance, I will be billed based upon their income. CCHS will have access to the SBHC patient health records for the purpose of attaining health care information.

Parent/Guardian Signature_____ **Date**_____

Caroline County School Based Health Program Student Health History _____ School Year

NAME _____ **Date of Birth** _____

List all medications your child takes daily or on a regular basis:

Medication _____mg _____ Directions _____

Medication _____mg _____ Directions _____

Medication _____mg _____ Directions _____

Allergies:

Medication ☐ No ☐ Yes Name of medication(s) _____

Reaction to medication(s) _____

Food ☐ No ☐ Yes Source of Allergy _____

Environmental ☐ No ☐ Yes Source of Allergy _____

Does your child have a doctor's order for an Epipen? ☐ No ☐ Yes

Does anyone in your home smoke? ☐ No ☐ Yes

Hospitalizations:

Reason _____ Date _____

Reason _____ Date _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? **CONDITIONS**	CHECK ALL THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **FAMILY MEMBER**	**ADDITIONAL INFORMATION** TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
ADD/ADHD			
ANEMIA			
ASTHMA			
BLEEDING DISORDER			
CANCER			
DEPRESSION/MENTAL ILLNESS Would you like your child referred to a Mental Health Counselor? Yes / No			
DEVELOPMENTAL DISABILITIES			
DIABETES			
DRUGS/ALCOHOL/TOBACCO USE BY STUDENT/HOUSEHOLD			
FREQUENT COLDS			
FREQUENT EAR INFECTIONS			
HEARING/VISION PROBLEMS/LOSS			
HEART PROBLEMS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
KIDNEY/BLADDER PROBLEMS			
LEAD POISONING			
LIVER PROBLEMS (HEPATITIS)			
MIGRAINES			
STOMACH PROBLEMS			
			CONTINUE ON NEXT PAGE ►

NAME _____ **Date of Birth** _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? **CONDITIONS**	CHECK ALL THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **FAMILY MEMBER**	**ADDITIONAL INFORMATION** TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
OBESITY			
SEIZURE DISORDER (EPILEPSY)			
SKIN PROBLEMS (ACNE,ECZEMA,PSORIASIS)			
STROKE			
THYROID DISEASE			
TOOTH DECAY			
TUBERCULOSIS			
WHEEZING or TROUBLE BREATHING			
ANY OTHER HEALTH ISSUES:			

Birth History: Birth Order 1 2 3 4 5 6 _____ Delivery Method ☐ Vaginal ☐ C-Section

Problems during pregnancy _____

During pregnancy, was your child exposed to: Medications Y / N Drugs: Y / N Alcohol: Y / N Smoking: Y / N

Did your child go home from the hospital with you? If not, why? _____

For children aged 0 – 6 years:	**YES**	**NO**
1. Does your child live in or regularly visit a house* built before 1950?	☐	☐
2. Does your child live in or regularly visit a house built before 1978 with recent renovations or remodeling done within the last six months?	☐	☐
3. Does your child have a sibling or playmate that has or did have lead poisoning?	☐	☐
For children of all ages:		
1. Was your child born in, or lived more than 1 year in a country other than the US? Where? _____ When? _____	☐	☐
2. Has your child been exposed to anyone who has ever had Tuberculosis?	☐	☐
3. Is your child currently living in a household with anyone who is HIV positive?	☐	☐
4. Is your child part of a migrant worker family?	☐	☐

* Daycare, Babysitter or Relative's home

This information is for use by the School Based Health Centers and is not part of the Caroline County Public School records.

Signature of Parent/Guardian completing this form _____

Date _____

School Year _____