Dear Parent/Guardian-

Your student's school and Shalom Health Care Center, have joined forces to operate a school-based health clinic, providing access to quality health services for students. It is our goal to help your family by providing medical services for your child while they are in school, assisting your child's physician with their healthcare needs, and providing access to healthcare for those who do not have any health services.

Our clinics are staffed with RNs, LPNs, or Pediatric Nurse Practitioner s with a Medical Assistant (in certain clinics). A Nurse Practitioner is an advanced practice nurse with a Master's degree or higher that has been trained to diagnose and treat.

Examples of services provided:

- First aid for acute illness or injury
- Diagnosis and treatment of infections (ear infections, strep throat, pink eye, etc.) NP clinics only
- Assistance in chronic care management (asthma, ADHD, seizure disorders, diabetes, etc.)
- Assistance in finding a Primary Care Provider
- Personal Health Counseling
- Immunizations (only certain clinics)
- Sport and camp physicals
- Referrals to other medical and social services as needed

Our services are not intended to replace your child's primary care provider. Our intent is to expand access to healthcare by working with families and their health providers to offer quality health care in the school setting.

Services not provided include:

- Treatment of complex medical or mental health problems
- X-rays and hospitalizations
- Birth control or other contraception

In accordance with Indiana State Law, all families wishing to receive health services from Shalom's school-based clinics **must sign a consent to treat form**. We also ask that you fill out a brief medical history form to provide our Nurse Practitioners with the most up-to-date medical information for your child. Any information given will remain confidential as part of your child's medical record

This program is provided at **no cost** to you or your family. Shalom will bill and collect from Medicaid (Hoosier Healthwise) and other third party health insurance your child may have.

Thank you for your cooperation and allowing us to participate in your child's health care needs.

Notice of Privacy Practices Summary

This summary describes how Shalom uses and shares your information and how you may acquire copies of this information. The full Notice of Privacy Practices is available at www.shalomhealthcenter.org as well as each of our clinics.

We may use or share your information for the following:

- **Treatment-**such as discussions of your care amongst the medical staff.
- **Payment-**such as billing insurance for services provided to you.
- **Operations-**such as working to improve our quality of care, advertising services provided, etc.
- **Other ways**- such as mandatory disease reporting to county and state health officials, responding to court requests, appointment reminders, test result letters, etc.

Exceptions- Different laws may apply to mental health, drug and alcohol and AIDS/HIV treatment.

Any other reasons for use or sharing of your health information will be completed only with your specific written permission or as required by law.

Regarding your information, you have the following rights:

- Requesting restrictions on how your information is shared. Shalom is not required to agree to requested restrictions but will notify you if we cannot accommodate your request.
- Acquire and inspect a copy of your health record.
- Ask that incorrect or incomplete information in your medical record be corrected.
- Ask that we contact you by mail or phone to an alternate address and/or phone number.
- Change your mind if you previously granted sharing/use of your information for reasons other than those listed above.
- Receive a list of the times we shared your information. This list will only contain the times that the law requires us to record.

Changes:

As we serve our patients, we may change how we handle your information. If we make any changes, we will give you a new notice the next time you visit our clinic. You may call or write at any time to check if we have made any changes.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with Shalom's Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services. Your care will not be affected in any way if you choose to file a complaint.

Please address questions or complaints to:

Shalom Privacy Officer
3400 Lafayette Road, Suite 200
Indianapolis, IN 46222
(317) 291-7422

Informed Consent for School-Based Health Clinic Services
as provided by Shalom Health Care Center Inc.

I give permission for (student's full name) _____ to receive health services from the school-based clinic at my child's school. I understand that the school-based clinic provider does not replace my child's Primary Care Provider and cannot take care of all my child's health care needs.

I. I have read the information provided regarding the school-based health clinic and the release of information and I understand what services the school-based clinic will and will not provide. **My consent will allow my child to receive health services** while he/she is a student at this school. I understand that if I chose to cancel these services, I must provide the request in writing. It will be my responsibility to notify the clinic staff regarding changes in guardianship, contact information and health history.

II. **Information Privacy** : I have been informed that Shalom has prepared a detailed NOTICE OF PRIVACY PRACTICES regarding my child's personal health information. I understand that the terms of the notice may change, and current notices will be available on Shalom's website and facilities.

III. **Release of Information**: **I understand the services provided by the school-based health care clinic are confidential.** The clinic will use and disclose my child's personal health information to provide treatment and for improvement of healthcare operations. My child's information may be shared with my child's physician/provider, appropriate school staff, or with my child's insurance provider for legitimate purposes. I authorize the release of my child's medical information to other providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation. In addition, I give my consent to the clinic staff to look at my child's school health record, including immunizations.

_____**(Parent's initials)** I acknowledge that I have received a copy of the Shalom Health Care Center Inc. **NOTICE OF PRIVACY PRACTICES.**

Signature of Parent/Guardian:_____ Date:_____

SERVICES WILL NOT BE PROVIDED WITHOUT PARENTAL CONSENT AS REQUIRED BY THE INDIANA STATE LAW.

HEALTH HISTORY FORM-MEDICAL INFORMATION

Student's Full Name:_____ Sex: M □ F □

Grade:_____ Date of Birth ____/_____/_____ Race:_____ Doctor:_____

Student Address:_____ Apt#_____City_____Zip_____

Current medication(s): _____

Allergies (food, medication, insects, etc.):_____

	Yes	No		Yes	No		Yes	No
Allergies-seasonal			Diabetes			Painful Periods		
Asthma			Fainting			Seizures		
Bed Wetting			Headaches or Migraines			Sickle Cell Anemia		
Birth Defects			Hearing Problems (hearing aids or devices)			Skin Disorders		
Bladder Infections			Heart Disease			Vision Problems (glasses or contacts)		
Blood Disorder			Heart Murmur			Other (specify):		
Cancer/Leukemia			Kidney Disease					

Please explain areas above marked **YES**_____

Mental Health Conditions (ADHD/Autism/Eating Disorders/Depression etc.

_____

If YES, do they see a mental health specialist? _____

Hospitalizations/Surgeries_____

Other important Health Information_____

_____

Contact Names and Phone Numbers in case of need:

Parent/Guardian:_____ Phone #_____

Parent/Guardian:_____ Phone#_____

Emergency Contact:_____Phone #_____

Family's Total Gross Income before taxes**: _____ per Week □ Bi-week □ Month □ Year □

How many people does this income support**_____

Does your child qualify for the free lunch program? _____

What type of health insurance does your child have?

Hoosier Healthwise / Medicaid Hoosier Healthwise #:_____

Advantage Advantage #: _____

Private Insurance Company Name: _____Member #_____

Providing this information will enable the continuation of school-based clinics and care for your child. Thank you!

***Shalom's School-Based Clinics have over the counter medications in stock (e.g. tylenol, ibuprofen, cough drops, hydrocortisone cream) that may be made available to your child depending on their symptoms. If you DO NOT wish the clinic to provide your child any over the counter medications please initial here:

I **DO NOT** permit Shalom SBC staff to provide my child with over the counter medication _____