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 healthcare services.

Our clinics are staffed with RNs, LPNs, or 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.

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.

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 medical staff 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 consent form is accepted at any school with a Shalom SBC, good through the student's senior year of high school. ***A written request to withdraw consent for treatment must be completed by the parent or guardian in order to discontinue services.*** *The parent or guardian is responsible for notifying the clinic of any changes to the student's health history, guardianship and/or demographic information.*

This program is provided at no cost to you or your family. Shalom will bill and collect from Medicaid and other third party health insurances your child may have. ***We do require insurance information be provided in order to provide services.*** *This ensures our ability to continue school-based clinic services and care for your child.*

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 child's 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 child's information for the following:

- **Treatment-**such as discussions of your child's care amongst the medical staff.
- **Payment-**such as billing insurance for services provided to your child.
- **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, family planning, drug and alcohol and AIDS/HIV treatment.

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

Regarding your child's information, you have the following rights:

- Requesting restrictions on how your child's 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 child's health record.
- Ask that incorrect or incomplete information in your child's 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 child's information for reasons other than those listed above.
- Receive a list of the times we shared your child's 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 child's 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 (SBC) 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 clinic will and will not provide. **My consent will allow my child to receive health services** while he/she is a student at any school with a Shalom SBC. 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, and update 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:_____Email Address:_____

Student Address:_____Apt#_____City_____Zip_____

Current medication(s): _____

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

Preferred Pharmacy: _____ (include intersection if unsure of address)

Primary Care Provider:_____ Phone:_____

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

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:_____Relationship to student:_____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? □Yes □No

We are required as an FQHC (Federally Qualified Health Center) to attempt to collect this information for data reporting only. Submissions remain anonymous

What type of health insurance does your child have? REQUIRED (YOU WILL NOT RECEIVE A BILL)

□Medicaid Number#:_____

□Private Insurance: Company Name:_____Member #_____

□No Insurance

****Insurance information is required to participate in Shalom School-based clinic program****

***Shalom's School-Based Clinics have over the counter medications in stock (e.g. Tylenol, ibuprofen, hydrocortisone cream etc.) 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 _____