SCHOOL-BASED HEALTH CENTER (SBHC) REGISTRATION PACKET FOR STUDENTS 11 AND UNDER

Austin D. Baltz Elementary School
1500 Spruce Avenue
Wilmington, DE 19805
Phone: (302) 651-2696

Dickinson High School and Middle School
1801 Milltown Road
Wilmington, DE 19808
Phone: 302-892-3270
Fax: 302-892-3274

Shortlidge Academy
100 West 18th **Street**
Wilmington, DE 19802
Phone: (302) 425-3389

Brookside Elementary School
800 Marrows Road
Newark, DE 19713
Phone: 302-454-5454
Fax: 302-454-3480

Richardson Park Pre-K Learning Center @ Warner
801 West 18th Street
Wilmington, DE 19802
Phone: (302) 425-3350

Silver Lake Elementary School
200 East Cochran Street
Middletown, DE 19709
Phone: 302-378-5046
Fax:302-378-5092

Conrad Middle School and Schools of Science
201 Jackson Avenue
Wilmington, DE 19805
Phone: 302-992-5532
Fax: 302-636-5680

Richardson Park Elementary School
16 Idella Avenue
Wilmington, DE 19804
Phone: 302-651-2732 ext. 754835

Warner Elementary School
801 West 18th Street
Wilmington, DE 19802
Phone: (302) 425-3350

Dear Parents/Guardians:

The School-Based Health Center (SBHC) is a partnership between ChristianaCare Health Services and Your School District. This letter is an invitation to sign up your child in the SBHC.

Health care in the SBHC is provided by a multi-disciplinary team. An Advanced Practice Clinician, a Licensed Clinical Social Worker/Licensed Professional Counselor of Mental Health, a Registered Dietitian, and a Community Health Worker provide care at your child's school.

To sign up your child in the SBHC, you need to provide the following:

- **Up-to-date insurance information** is needed if your child is insured. (Note: No co-pay, co-insurance or deductible will be charged to you, and no one will be turned away based on ability to pay.)
- **A completed Consent Form** (included in this packet).
- A completed **Student Registration Form** and **Health History Form** (included in this packet).

The completed enrollment/registration forms should be returned to the SBHC as soon as possible.

SBHC services offered:

- Physicals
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses and injuries
- Counseling (individual, family, and group)
- Crisis intervention and suicide prevention
- Health education/risk reduction

Please know that your child's pediatrician or family doctor will still be your child's primary care provider. The SBHC does not take the place of your child's pediatrician or family doctor, and SBHC doctors and nurses will work with your child's primary care provider to care for your child. The SBHC offers services that may add to the care provided by your primary care provider. When appropriate, and with your permission, we will try to share medical information with your child's doctor to prevent any duplication of health care services, and to take good care of your child. If your child does not have a doctor, we can help you find one.

We hope that you will register your child in the SBHC.

Then, together with you and your child's primary care provider, we can work towards keeping your child healthy and in school. Please encourage your child's pediatrician or family doctor to call the SBHC with questions. If you have questions or need more information, please call the School-Based Health Center.

24770 (15581)(0224)A

ChristianaCare

CNSNT

School-Based Health Center (SBHC) For Students 11 and Under

PATIENT/STUDENT CONSENT FOR SERVICES

I, _____ , give my consent for _____ _____ /_____ /_____
(Parent/Legal Guardian of Student) (Name of Student) Date of Birth

who resides at: _____
(Street Address)

_____
(City, State, Zip Code

to receive health services at the _____ School-Based Health Center administered by **ChristianaCare Health Services.**

Services Provided by the School-Based Health Center:

- Health assessments
- Vaccines
- Diagnosis and treatment of medical problems.
- Diagnosis and treatment of sexually transmitted infections
- Pregnancy screening
- Referrals to and follow up for oral, vision, and/or specialty care.
- Mental health and substance use disorder assessments, crisis intervention, counseling, and treatment.*
- Referral to mental health and substance abuse services including emergency psychiatric care, community, and support programs.*

Services Not Provided by the School-Based Health Center:

- Treatment or testing of complex health and mental health problems.
- Complex lab tests,
- Hospitalization,
- X-Rays,
- and Emergency Care.

In consenting to permit my child to participate in the School-Based Health Center, I acknowledge and agree to the following:

I have had the opportunity to review the ChristianaCare Health Services' Notice of Privacy Practices (NPP)- Summary, which is also available in Arabic, Bengali, Haitian Creole, Korean, Spanish and Simplified Chinese upon request. I understand that the full Notice of Privacy Practices is available upon request.

I understand that insurance may be billed for covered services, and I agree to provide insurance information before services are provided.

I understand that the School-Based Health Center does not charge co-pays or any other out-of-pocket fees for use of School-Based Health Center Services.

I give permission for ChristianaCare and its business associates to use any telephone number provided by me, on behalf of my child, regardless of whether it is a cell phone number and/or whether I may be charged for the call or text. The telephone number(s) may be used for healthcare and account matters (including collections) and include automatic telephone dialers and/or pre-recorded calls and/or text messages..I understand that my consent to use my telephone number is not required to receive health care services. This telephone consent applies to all past, present, and future ChristianaCare services until revoked.

I understand that the School-Based Health Center may use telehealth to provide services, including, medical, mental health, and community health worker services. The video conference between student and provider or community health worker does not involve data storage, recording, or archiving. Telehealth encounters are subject to the same protection under the HIPAA Privacy Rules as a face-to-face visit.

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REGISTRATION PACKET

I understand that "telehealth" is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as the provider.

I understand that a telehealth visit is not the same as an in-person visit because my child will not be in the same room with the provider. I understand that my child will not be treated through telehealth unless their condition supports the use of this technology.

I understand the provider will not be able to complete a full physical exam through telehealth.

I understand that digital communication may include, but not be limited to real time two-way audio, video, or other communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my child's care team.

I understand that there are benefits to using telehealth services, which include, but are not limited to, convenient medical evaluation and treatment. I also understand that there are risks involved with telehealth, which include, but are not limited to interruption in the connection that may result in the visit being postponed and/or performed using a different method, and, in rare cases, unauthorized access to my child's confidential information. In the event of a technical failure, I understand that I should contact my child's provider's office right away or call 9-1-1 if it is an emergency.

I understand that laws protecting the confidentiality of my child's medical information also apply to telehealth and that ChristianaCare uses security protocols to help protect my child's privacy and ensure my child's confidential communications are sent only to the intended care team member(s).

I understand that ChristianaCare will not record the video or audio of my child's telehealth visit without my consent at the time of the recording.

I consent to have ChristianaCare obtain health information from my child and provide health care services to my child through telehealth when and where the provider or care team determines it is appropriate and necessary.

I understand that I may refuse or stop telehealth services and request alternate services, such as an in-person visit, at any time.

I understand that, with my permission and at my request, my child may be seen at a different School-Based Health Center within the School District for certain services.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. I understand that any requests in writing must be sent to the School-Based Health Center associated with my student's care.

I agree that school staff can accompany my child for medical exam.

I acknowledge that all information on the registration Health History Form and this consent is accurate and complete.

I have read this form carefully. All my questions have been answered to my satisfaction. I understand that I may call the School-Based Health Center Coordinator if I have any questions before or after I sign this consent for services.

By signing below, I certify that I am the parent or legal guardian of the student named above and have read the above consent statements about services offered at my child's School-Based Health Center and voluntarily agree to have my child participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

_____	_____	___/___/___	_____
Patient/Representative Signature	Patient Representative Relationship to Patient	Date	Time

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CNSNT

School-Based Health Center (SBHC) For Students 11 and Under

APPOINTMENT OF DECISION MAKER FOR MINOR

I , ______________________________ , the ______________________________ of this child, appoint
(Parent/Guardian Name) (Relationship to Child)

the following to be a decision maker(s) for my child ______________________________ in my absence:
(Name of Child)

Name of Decision Maker	Relationship to Minor Child

I authorize the above decision maker to give consent for treatment of the following:

☐ Routine health maintenance (physical exams) ☐ Medical care for illness
☐ Immunizations (sign consent for shots) ☐ X-rays and laboratory tests

Name of Decision Maker	Relationship to Minor Child

I authorize the above decision maker to give consent for treatment of the following:

☐ Routine health maintenance (physical exams) ☐ Medical care for illness
☐ Immunizations (sign consent for shots) ☐ X-rays and laboratory tests

Name of Decision Maker	Relationship to Minor Child

I authorize the above decision maker to give consent for treatment of the following:

☐ Routine health maintenance (physical exams) ☐ Medical care for illness
☐ Immunizations (sign consent for shots) ☐ X-rays and laboratory tests

Name of Decision Maker	Relationship to Minor Child

I authorize the above decision maker to give consent for treatment of the following:

☐ Routine health maintenance (physical exams) ☐ Medical care for illness
☐ Immunizations (sign consent for shots) ☐ X-rays and laboratory tests

Name of Decision Maker	Relationship to Minor Child

I authorize the above decision maker to give consent for treatment of the following:

☐ Routine health maintenance (physical exams) ☐ Medical care for illness
☐ Immunizations (sign consent for shots) ☐ X-rays and laboratory tests

I am authorizing the person(s) named above to bring my child for medical care and treatment. This appointment of alternate decision maker expires on: ______ /______ /______ or the child's 18th birthday. To cancel this appointment of the decision
(Date)
maker, please provide this office with written notification.

Parent/Guardian Signature	Relationship to Patient	Date ___/___/___	Time
Witness Signature	Witness Print Name	Date ___/___/___	Time

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School-Based Health Center (SBHC) For Students 11 and Under

APPOINTMENT OF DECISION MAKER FOR MINOR

Telephone Consent:

_____ _____

Name of person providing consent | Relationship to Patient if Decision Maker

_____ ___/___/___ _____

Witness Signature | Date | Time

_____ ___/___/___ _____

Witness Signature | Date | Time

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ Language

The person who provided the interpretation is a qualified medical interpreter.

_____ _____

Interpreter Name | Agency and ID# (if applicable)

_____ _____ ___/___/___ _____

Witness Signature/Title | Print Name or ID# | Date | Time

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AINFO

School-Based Health Center (SBHC) For Students 11 and Under

PATIENT REGISTRATION

Patient (Student) Information – Please Print (in pen)

Grade: ☐ Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Patient's Last Name: **First:** **Middle:**

Preferred First Name: **Nickname:**

Birth Sex: ☐ Male ☐ Female

Preferred Language:

Gender Identity: ☐ Male/man/boy ☐ Female/woman/girl ☐ Transgender Male/man/boy ☐ Transgender Female/woman/girl ☐ Nonbinary, genderqueer, or not exclusively male or female ☐ Prefer not to answer

Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ No Pronouns ☐ Declines to Specify ☐ Other: _____

Address: **City** **State** **Zip Code**

Birthdate:

Race (mark all that apply):
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White
☐ More than one race ☐ Declined/Not available ☐ Other race: _____

Ethnicity: (mark all that apply):
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Declined/Not available

Primary Care Physician (Family Doctor)
Name: _____
Phone Number: _____

Preferred Pharmacy:
Name: _____
Phone Number: _____

In case of an emergency contact:
Relationship to patient: _____
Phone Number: _____

Student's Cell Phone #:

Is patient employed?
☐ Yes ☐ No ☐ Not applicable

Parental/Legal Guardian Information

Mother's Full Legal Name: **Date of Birth:**

Address: Home Phone #:

Email Address: Cell Phone #:

Employer Name & Address: Work Phone #:

Father's Full Legal Name: **Date of Birth:**

Address: Home Phone #:

Email Address: Cell Phone #:

Employer Name & Address: Work Phone #:

Legal Guardian Name (if not mother or father): **Relationship to Student** **Date of Birth:**

Address: Home Phone #:

Email Address: Cell Phone #:

Employer Name & Address: Work Phone #:

▶ **Insurance Information (REQUIRED) –** ***Send in a Copy Front and Back of Insurance Card***

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School-Based Health Center (SBHC) For Students 11 and Under

REGISTRATION PACKET

Source of payment for care, please check one of the following:	***Secondary Insurance Information:***
☐ **No Insurance**	
☐ **Medicaid Provider:** _____	☐ **Medicaid Provider:** _____
Medicaid Number: _____	**Medicaid Number:** _____
☐ **Commercial Insurance:** _____	☐ **Commercial Insurance:** _____
Policy Number: _____	**Policy Number:** _____
Subscriber Name: _____	**Subscriber Name:** _____
Relationship to Student: _____	**Relationship to Student:** _____
Subscriber Birthdate: _____	**Subscriber Birthdate:** _____
☐ **Delaware Healthy Children Program**	

_____	_____	_____	___/___/___	_____
Signature of Parent/Guardian	Print Name	Relationship to Student	Date	Time

ChristianaCare

ENCBASFRM

School-Based Health Center (SBHC) For Students 11 and Under

HEALTH HISTORY FORM

A complete and accurate health history is needed so that Center staff can provide high quality care. Please print all information and complete this form as much as possible.

Student's Name _____ DOB ____ /____ /____ Grade _____
(Last) (First) (MI)

Does your child have any allergies? (i.e., food, medication, latex)

☐ Yes ☐ No If yes, please list?_____

Please provide the following information about medicines your child is taking.

Name of medicines	Reason taken	How long taken

Primary Care Provider Name: _____ Date of Last Physical: ____ /____ /____

Please check which of the following your **CHILD** has ever had:

☐ Acne/Skin Problems	☐ Diabetes	☐ Hepatitis	☐ Sickle Cell
☐ ADHD/learning disability	☐ Depression	☐ High Blood Pressure	☐ Sleeping Problems
☐ Anemia	☐ Fainting Spells	☐ High Cholesterol	☐ Sports Injury
☐ Anxiety	☐ Frequent Colds	☐ Kidney/Bladder Disease	☐ Stomach/Intestinal Problems
☐ Arthritis	☐ Headaches	☐ Pregnancy/Child Birth/Miscarriage	☐ Suicide Attempts
☐ Asthma	☐ Head Injury	☐ Rheumatic Heart Disease	☐ Suicidal Thoughts
☐ Cancer	☐ Heart Disease	☐ Scoliosis	☐ Substance Abuse
☐ Chicken Pox	☐ Heart Murmur	☐ Seasonal Allergies	☐ Thyroid Disease
☐ Cystic Fibrosis	☐ Hemophilia	☐ Seizures	☐ Tuberculosis

If any of the above is checked, please give more detail._____

_____

Has your child ever been hospitalized or received counseling for emotional or behavioral health?

☐ No ☐ Yes, when: _____ Where? _____

Reason: _____

Please check any of the following illnesses that your **FAMILY MEMBERS** (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and write in which family member next to the illness.

☐ ADHD/learning disability _____	☐ Diabetes _____	☐ Obesity _____
☐ Alcoholism/Drug Abuse _____	☐ Headaches _____	☐ Seizures _____
☐ Anemia _____	☐ Heart Disease _____	☐ Sickle Cell _____
☐ Arthritis _____	☐ Hemophilia _____	☐ Stroke _____
☐ Asthma _____	☐ Hepatitis _____	☐ Thyroid Disease _____
☐ Birth defects _____	☐ High Blood Pressure _____	☐ Tuberculosis _____
☐ Cancer _____	☐ High Cholesterol _____	☐ Unexplained Death _____
☐ Cystic Fibrosis _____	☐ Kidney/Bladder Disease _____	☐ Other _____
☐ Deafness _____	☐ Mental Illness _____	

Signature of Parent/Guardian	Print Name	Relationship to Student	Date	Time
_____	_____	_____	___/___/___	_____

Privacy Office
4000 Nexus Drive, Avenue North – Suite NW3-100,
Wilmington, DE 19803
Telephone No.: 302-623-4468, Fax No.: 302-428-2475

Effective Date: September 23, 2013
Last Revised Date: September 27, 2021

HIPAA Notice of Privacy Practices (NPP): Please Review It Carefully!

This Summary NPP or Notice is about Your Information, Your Rights, and Our Responsibilities. It describes how your information may be used and disclosed by ChristianaCare, and how you can get access to it. ChristianaCare takes our patients' privacy seriously. We know that your medical information is very personal. We do our best to protect the privacy of your medical information. We will only use and disclose the minimum necessary information for the intended purpose and as required by law. You can ask for a copy of our detailed NPP or access it on our website www.christianacare.org/privacy.

Our Responsibilities	To serve you, we create and receive personal information about your health. This information is called Protected Health Information (PHI), and it comes from you, your physicians, hospitals, and other healthcare service providers involved in your care. For members of the ChristianaCare Health & Welfare Benefits Plan (benefits plan), PHI may come from your employer, other insurers, Health Maintenance Organizations (HMOs) or third-party administrators (TPAs), as applicable. Your PHI can be in oral, written, or electronic format. We are required by law to: • maintain the privacy and security of your PHI. • enter into a Business Associate Agreement with third parties who participate in your treatment, payment, and our health care operations that requires the business associate to protect the privacy and security of PHI. • notify you promptly if we determine inappropriate use or disclosure of your PHI has occurred that compromises the privacy or security of your information. • use and disclose your information, as described in this Notice, unless you tell us we cannot in writing. If you change your mind at any time, you must tell us in writing. • follow the duties and privacy practices described in this Notice and give you a copy of it.
Who will follow this Notice?	• All ChristianaCare organizations, facilities, and medical practices • Any doctor, health care professional, or other person caring for you • All people who work for ChristianaCare • All ChristianaCare volunteers • Any business associate needing health information, so they can provide services for ChristianaCare
Your Information	
We may store the following information about you:	The information we may store includes, but is not limited to: • Clinical Data: Diagnoses/Conditions, Lab Results, Medications, Other Treatment Information • Demographic Data: Address/Zip Code, Date of Birth, Driver's License, Name, Social Security Number, Other Identifiers • Financial Data: Claims Information, Credit Card/Bank Account Number, Other Financial Information, Name, and Driver's License Information
Our Uses and Disclosures	
We may use and disclose your information for purposes of:	This section describes how we may use and give out medical information about you. Although this list does not contain every possibility, all of the ways that we are allowed to use and give out information without your permission will fall within one of the categories listed in this section. We may use and disclose your information for the following situations, including, but not limited to: • Helping to manage the health care treatment you receive • Coordinating your care among various health care providers • Collecting standardized assessment information to complete a Home Health Assessment on admission • Billing for your health services and managing our health care operations • Conducting research

	• Complying with the law or helping with public health and safety issues • Responding to organ and tissue donation requests, medical examiners, and funeral directors • Addressing workers' compensation, law enforcement, and other government requests • Responding to lawsuits and legal actions • Administering your health plan, as applicable for benefits plan members • Provisioning of services and programs for benefits plan members • Conducting marketing and fundraising activities
Your Choice	
You have some choices in the way that we use and share your information for purposes of:	You may choose how we use and share your information for the following situations, including, but not limited to: • Responding to treatment-related questions from your family and friends • During disaster relief • Communicating with you through mobile and digital technologies • Marketing our services and products
Your Rights	
Your rights include:	When it comes to your health information, you have certain rights. This section describes your rights and our responsibilities to help you. Your rights include, but are not limited to, the following: • Getting a copy of your health and claims records • Requesting correction of your health and claims records • Getting a list of those with whom we have shared your information • Asking us to limit the information we share • Requesting confidential communication • Requesting a copy of this privacy Notice • Filing a complaint if you believe your privacy rights have been violated • Choosing someone to act on your behalf
Special Situations	
We are allowed or required to share your information in other ways without your permission. The following uses and disclosures are considered special situations: for research purposes; for law enforcement purposes; to help avoid a serious threat to public health or safety; responding to public health authorities; for home health assessments; responding to organ and tissue donation requests; to coroners, medical examiners, and funeral directors; to the military; for workers' compensation; for health oversight activities; for lawsuits and disputes; to correctional institutions; for national security and intelligence activities; and additional restrictions on use and disclosure. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.	
Health Information Exchange	
ChristianaCare participates in several Health Information Exchanges (HIEs) and Health Information Networks (HINs). The HIEs and HINs coordinate information sharing among their members for treatment, payment, and health care operations. Through these exchanges, ChristianaCare can share your health information with your other providers ensuring timely delivery of vital health information to your health care providers. We participate in the following HIEs: Delaware Health Information Network (DHIN); Chesapeake Regional Information System for our Patients (CRISP); Healthshare Exchange of Southeastern Pennsylvania Inc. (HSX); and CommonWell Health Alliance (CommonWell). Patients may opt-out of an electronic HIE on the HIE's website.	

Changes to this Notice. We have the right to change this Notice. All changes to the Notice will apply to the information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice in the hospital and on our website www.christianacare.org/privacy. The effective date of the current Notice will be posted at the top of the Notice. If we make material changes to this Notice, we will provide you with the updated Notice at your next visit.

How to contact us. If you have any questions about this Notice, or if you need to make a request to the Privacy Officer, please contact us at ChristianaCare c/o Privacy Officer, 4000 Nexus Drive, Avenue North, Suite NW3-100, Wilmington, DE 19803, or 1-302-623-4468, or email us at privacyoffice@ChristianaCare.org. A detailed Notice of our Privacy Practices is available upon request.