



SCHOOL-BASED HEALTH CENTER

Cab Calloway Middle School
100 N. DuPont Road
Wilmington, DE 19807
Phone: 302-651-2100 Fax 302-651-2111

REGISTRATION FOR 11 YEAR OLDS ONLY

Dear Parents/Guardians:

The Wilmington Cab Calloway/Charter School-Based Health Center (SBHC) is a partnership between Christiana Care Health Services and Red Clay School District. This letter is an invitation to sign up your child for services in the SBHC. **At the age of 12 a new consent will be need to be signed.**

Health care in the SBHC is provided by a multi-disciplinary team. A Nurse Practitioner, a Licensed Clinical Social Worker/ Licensed Professional Counselor of Mental Health, and a Registered Dietitian 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:

- Counseling (individual, family, and group)
- Health education/risk reduction
- Crisis intervention and suicide prevention
- Nutrition/weight management
- Physicals (sports, school, or pre-employment)
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses/injuries

Please know that your child's pediatrician or family doctor will still be your child's main doctor. 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 main doctor to care for your child. The SBHC offers services that may add to the care provided by your main doctor. 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 main doctor, 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 Wilmington Cab Calloway/Charter School-Based Health Center at (302) 651-2100.**

Sincerely,

Jenny Stamatiadis, LCSW, Site Coordinator

302-651-2100

Kathy Cannatelli, MS,

Manager Community Health and Preventive Medicine

302-428-6557

Martha Coppage-Lawrence, CPNP, Lead Nurse Practitioner,

School-Based Health Centers for Christiana Care

302-428-6558

**SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES
Cab Calloway Middle School, Red Clay School District**

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

to receive health services at the Wilmington Cab Calloway/Charter School-Based Health Center administered by Christiana Care Health Services.

Services Provided:

- Comprehensive health assessments (for students without a primary care physician)
- Immunizations
- Diagnosis and treatment of minor, acute and chronic medical Conditions
- Nutrition Counseling and education
- Referrals to and follow up for specialty care, oral and vision health services
- Mental health, crisis intervention, counseling and treatment
- Referral to mental health and substance abuse services including emergency psychiatric care, community and support program

THE SCHOOL-BASED HEALTH CENTER DOES NOT PROVIDE THE FOLLOWING SERVICES:

- Treatment or testing of complex medical or psychiatric conditions
- Ongoing primary treatment of chronic medical conditions
- Complex lab tests
- Hospitalization
- X-Rays

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

1. I have had the opportunity to receive and review the Christiana Care Health Services' Notice of Privacy Practices brochure which is attached.
2. **I understand** that the School-Based Health Center may use telehealth to provide mental health services. The video conference between student and mental health provider will not involve data storage, recording, or archiving. Telemedicine encounters are subject to the requirements of the HIPAA Privacy Rule that apply to Protected Health Information.
3. **I understand** that insurance may be billed for covered services and I agree to provide insurance information before services are provided.
4. **I understand** that the School-Based Health Center shall not charge co-pays or any other out-of-pocket fees for use of its services.
5. **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. The revocation must be in writing and sent to the School-Based Health Center associated with my student's care.
6. **I agree** that all information provided on the registration Health History Form and this consent is accurate and complete.
7. My student and 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 student's School-Based Health Center and voluntarily agree to have my student participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ **Date:** _____ **Time:** _____

**Christiana Care Health System School-Based Health Center
Patient Registration Form**

Patient (Student) Information – Please Print (<i>in pen</i>)					Grade: 6 7 8	
Patient's Last Name:		First:	Middle:			
Identified Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Decline to Answer						
Address:		City	State	Zip Code	Birthdate:	
Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native Undetermined Other				Ethnicity (please circle): Hispanic/Latino Arabic Non-hispanic/latino/arabic		
Primary Care Physician (Family Doctor) Name: _____ Phone Number: _____				In case of an emergency contact: _____ Relationship to patient: _____ Phone #: _____		

Parental/Legal Guardian Information

Mother's Full Legal Name:		Date of Birth:	
Address:		Home Phone#:	
Parent Email Address:		Cell Phone#:	
Employer Name & Address:		Work Phone#:	
Father's Full Legal Name:		Date of Birth:	Home Phone#:
Address:		Cell Phone#:	
Employer Name & Address:		Work Phone#:	
Legal Guardian Name (if not mother or father):	Relationship to Student	Date of Birth:	Home Phone#:
Address:		Cell Phone#:	
Employer Name & Address:		Work Phone#:	

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

<p>Source of payment for care, please check off one of the following:</p> <p><input type="checkbox"/> No Insurance</p> <p><input type="checkbox"/> Medicaid Provider: _____</p> <p>Medicaid Number: _____</p> <p><input type="checkbox"/> Commercial Insurance : _____</p> <p>Policy Number: _____</p> <p>Subscriber Name: _____</p> <p>Relationship to Student: _____</p> <p>Subscriber Birthdate: _____</p> <p><input type="checkbox"/> Delaware Healthy Children Program</p>	<p align="center"><i>Secondary Insurance Information:</i></p> <p><input type="checkbox"/> Medicaid Provider: _____</p> <p>Medicaid Number: _____</p> <p><input type="checkbox"/> Commercial Insurance: _____</p> <p>Policy Number: _____</p> <p>Subscriber Name: _____</p> <p>Relationship to Student: _____</p> <p>Subscriber Birthdate: _____</p>
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HEALTH HISTORY FORM

A complete and accurate health history is needed in order for Center staff to provide high quality care. Please complete this form as much as possible. Please print all information.

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

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

Yes No If yes, please list? _____

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

Name of medicines	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Provider Name: _____

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

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

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

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

Yes No If 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 indicate which family member next to the illness.

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

PARENTAL/GUARDIAN CONCERNS

If you have any concerns, please encourage your child to schedule a visit at the School-Based Health Center or you can feel free to call us to discuss your concerns.

If you would like assistance with establishing insurance, finding a doctor, or a dentist, please call the School-Based Health Center.

Notice of Privacy Practices

Effective Date: September 23, 2013

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. If you have a question, contact the Privacy Officer at (302) 623-4468.

Our promise

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 your information as allowed by applicable law.

We are required by law to:

- Do what this Notice says.
- Make sure that your information is kept private.
- Only disclose the minimum necessary information for the intended purpose.
- Tell you if there is a breach of your privacy.

Who will follow this notice?

- All Christiana Care organizations, facilities and medical practices.
- Any doctor or other person caring for you
- All people who work for Christiana Care
- All Christiana Care volunteers.
- Any business associate needing health information so they can provide services for us.

How we may use and give out medical information about you

Here is how we use and give out medical information.

Although this list is not complete, all of the ways we are allowed to use and give out information without your permission will fall within one of the headings listed.

- **To take care of you.** We may use your health information to give you medical care. We may give out medical information about you to doctors, doctors in training, nurses, students or other people in the hospital who are part of your care here. We may also give out medical information to work with people outside the hospital who provide care for you.
- **To get paid.** We may use and give out health information about you so that the care you receive here will get paid by you, an insurance company, or other payor. For example, we may tell your health plan about care you received, so it can pay us for that care. We may also tell your health plan about care you are going to get to find out if they will pay for that care.
- **To run Christiana Care.** We may use and give out medical information about you to run Christiana Care. We may also use your information to see how we took care of you and how you did. We may also put together medical information about many patients to decide if there are other services Christiana Care should offer, what services are needed or not needed, and what new treatments are effective. People taking care of you, including doctors, nurses, and students, may receive information for learning purposes. Information may be combined with medical information from other hospitals to compare how we are doing and see if we can improve the care and services we offer.
- **Fundraising activities.** We may contact you to ask for a donation. We have the right to use certain information for this purpose (including your contact information, age, gender, dates of service, department of service, treating physician, outcome information and health insurance status). If you do not wish to be contacted for our fundraising efforts, you may opt out by calling 1-800-693-2273, sending an email to optout@christianacare.org or writing to the Christiana Care Office of Development, 13 Reads Way, Suite 203, New Castle, DE 19720. We will not condition your treatment on your agreeing to be contacted for fundraising purposes.
- **Hospital directory.** If you are a patient in our hospital, we may include limited information about you in the hospital directory so your friends, family and clergy can visit you and find out how you are doing. This information may include your name, location in the hospital, phone number, your general condition (good, fair, serious or critical), and your religion. All information except for your religion may be given to people who ask for you by name. Your religion may be given to a member of the clergy, even if they don't ask for you by name. We may also tell that a patient has died after next of kin has been told. If you do not want anyone to know about you, you must sign a form that will be provided to you when you are admitted.
- **Family and friends.** We may give medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any health care power of attorney or similar document given to us. We may also give information to someone who helps pay for your care. In addition, we may give out medical information about you to an agency helping in a disaster relief effort so that your family can be contacted about your condition, status, and location.
- **Research.** In most cases, we will ask for your written approval before using your medical information or sharing it with others in order to carry out research. However, we may use and give your health information without your approval in the following ways:
 - If we have submitted it to a research committee and they have taken steps to make sure your information will be protected.
 - To people within Christiana Care who are preparing a research project or enrolling patients in research projects.

Special Situations

We may give out information about you without your permission in the following situations:

- **As required by law.** When we are required to do so by federal, state, or local law.
- **To help avoid a serious threat to health or safety.** To help avoid a threat to the health and safety of you, the public or another person.
- **Organ and tissue donation.** To agencies that handle organ, eye, and tissue donations, or to an organ donation bank so these organizations may assist transplantation.
- **Military and veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may give information to the Department of Veterans Affairs to find out if you can get certain benefits.
- **Workers' compensation.** We may share information to assist programs that provide benefits for work-related injuries or illness.
- **Public Health authorities.** We may provide information for Public Health activities, such as reporting disease outbreaks; births and deaths; child or elder abuse; reactions to medications; recall notifications; or communicable diseases.
- **Health oversight activities.** We may provide information to agencies monitoring the health care system or government programs or making sure hospitals are following the law. These activities include audits, investigations, inspections, and licensing.
- **Lawsuits and disputes.** If you are involved in a lawsuit or a dispute, we may give out medical information about you if we get a valid court or administrative order, subpoena, discovery request, or other legal request from someone involved in the case.
- **Law enforcement.** If we are asked to do so by law enforcement officials or are required to do so by law:
 - In response to a valid court order, subpoena, warrant, summons, or other similar process.

- To identify or find a suspect, fugitive, material witness, or missing person.
- To report about the victim of a crime if, in certain cases, we are unable to get the person to agree.

To report about a death we think may be the result of criminal conduct.

- To report criminal conduct in our facilities.
- In emergency cases to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

• **Deceased Individuals, Coroners, medical examiners, and funeral directors.** We may provide information to a coroner or medical examiner to identify a person who has died or find out why the person died. We may also give out medical information to funeral directors. We will protect the confidentiality of your medical information for 50 years following your death.

• **National security and intelligence activities.** We may provide information to authorized federal officials for national security activities authorized by law. This includes the protection of the President or foreign heads of state.

• **Prisoners.** If you are a prisoner of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the prison or law enforcement officials when necessary for your health and safety or the health and safety of others.

Delaware Health Information Network (DHIN)

We take part in a health information exchange called DHIN to help us share your health information with other doctors and health care organizations that take care of you and to get information from those other persons involved in your care. This allows each of us to provide better care and to coordinate your care. Information on DHIN's privacy practices is available on its website: www.dhin.org/consumer. To contact DHIN, call (302)678-0220.

When we need your written permission to give out your medical information

We will need your written permission to use or give out your medical information for any reasons that do not fall within the categories described above in this Notice. Specifically, we need your permission to use or release psychotherapy notes, to use information for marketing or to sell health information.

If you give us permission, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or share medical information about you, except for those activities and purposes not requiring your permission – such as to take care of you, get paid, and run Christiana Care. You understand that we are unable to take back any information we have already shared with your permission and that we have to keep records of all the care that we have given you.

Your rights regarding medical information about you

• **Right to look at and get a copy.** Most of the time, you have the right to look at and get a copy of your health information that may be used to make decisions about your care. To look at or get a copy of your health information, please write to Health Information Management Services. If it is a billing record, please contact the billing department where your service was provided. If you ask for a copy, we may charge a fee for the costs of copying, mailing or other supplies. You may ask us to provide a copy of your records in a specific electronic form or format. We will provide the copy in the requested form or format if it can be easily made. If not, we will arrange with you to provide the copy in another readable electronic form and format. On rare occasions, we may not be able to let you see or get copies of your records. If this happens, we will tell you the reason and you will have the right to request review of that decision.

• **Right to amend.** You have the right to ask for an amendment of information that is incorrect or incomplete for as long as the information is kept by the hospital. To ask for an amendment, you must write to the Privacy Officer and provide a reason. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by or for Christiana Care.
- Is not part of the information that you would be permitted to inspect and copy.
- Is accurate and complete. You have a right to submit a written statement to the Privacy Officer disagreeing with a denial of your request for an amendment and to have it released with your records.

• **Right to a list of disclosures.** You have the right to request an "accounting of disclosures" or a list of who outside of the hospital has received information about you. This does not apply to information given to take care of you, for Christiana Care to get paid, or to run Christiana Care. To ask for this list, you must put your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years. The first list you ask for within a 12-month period will be free. If you want more lists, we may charge you for the costs of providing the list. We will tell you the cost and get your approval before we mail the list.

• **Right to Notification of a Breach.** You have the right to receive notice if there is a breach of your unsecured protected health information (that is, an unauthorized acquisition, access, use or disclosure of protected health information that compromises the security or privacy of the information). This notice maybe given by mail or through the news media.

• **Right to ask for restrictions on the use or disclosure of your information.** You have the right to ask us to limit the medical information we use or give out about you. We may not be able to agree to your request. If we do agree, we will do as you ask unless the information is needed to provide you emergency treatment.

You may request that information about an item or service for which you have paid in full out of pocket not be disclosed for payment or health care operations. That information may still be used for treatment purposes or as required by law.

To ask for a restriction, you must send your request to the Privacy Officer, in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, how we share your information, or both; and (3) to whom you want the limits to apply, for example, information to your spouse.

• **Right to confidential communications.** You have the right to ask us to contact you using a different address or phone number so you can keep your health information private. When you provide your address when registering for services, you need to tell us you would like a second address or phone number to be used.

• **Right to a paper copy of this Notice.** To get a copy of this notice, ask for a copy from Patient Registration or the Privacy Officer.

Changes to this Notice

We have the right to change this Notice. All changes to the Notice will apply to 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 Web site: www.christianacare.org.

If we make material changes to this Notice, we will provide you with the updated Notice at your next visit.

Complaints

If you think your privacy rights have been violated, you may file a complaint with us by writing to the Christiana Care Privacy Officer. Please provide enough detail to allow us to look into the matter. You may also file a complaint with the Office of Civil Rights at: Regional Manager of the Office of Civil Rights, Region III, 150 S. Independence Mall W. Suite 372, Public Ledger Building Philadelphia, PA 19106-9111 (215) 861-4441, Hotline Number: 1-800-368-1019

PLEASE NOTE: You will not be treated any differently for filing a complaint.

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:

Christiana Care, c/o Privacy Officer, PO Box 6001, Newark, DE 19714-6001 (302) 623-4468