CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.

SCHOOL BASED HEALTH CENTERS

"HEALTHY KIDS MAKE BETTER LEARNERS"

Summer/Fall 2015

Dear Parent or Guardian:

As a student of Broadview Middle School, Rogers Park Middle School, or Danbury High School, your child has the unique opportunity to take advantage of medical services offered through a **School Based Health Center (SBHC)** located in the school building. The SBHC is affiliated with the Greater Danbury Community Health Center and is primarily staffed by a nurse practitioner, licensed clinical social worker or licensed professional counselor, and a medical/office assistant. All of the SBHC's health care professionals work collaboratively with school staff and community providers to provide quality and holistic health services.

Medical services include diagnosis and treatment of acute and chronic illnesses such as strep throat, ear infections, and asthma, as well as sports physicals and immunizations. Complete physical exams may also be available to your student. Health education and counseling is also offered, with topics ranging from nutrition and fitness to reproductive health. Mental Health services are comprised of individual, family, and group counseling for a variety of issues including anxiety, depression, family and peer relationships, poor academic performance, behavioral problems and eating disorders. Dental services are available on a limited basis at both the Danbury High School and Rogers Park Middle School sites. Care your student may receive includes exams, x-rays, cleanings, fillings, and fluoride treatments. A separate dental consent is required.

All services are provided at no out-of-pocket cost to the family. If your child has Connecticut HUSKY or private insurance, the SBHC may bill for services. Co-pays are not charged, and rejected claims are written off. Please contact the SBHC if you do not have insurance and are interested in information regarding HUSKY insurance.

In order for your child to take advantage of SBHC services, you must complete, sign and return the enclosed two-sided Parental Permission/Medical History Form, and a separate dental consent if requested. The SBHC sites do not provide dental treatment to students with private dental insurance. The SBHC Privacy Policy is included on the back of this letter.. If you have previously enrolled your student in the SBHC, thank you, and please take a moment to update your student's information.

The staff looks forward to working with you to help your child be healthy, happy and ready to learn! If you have any questions about the services offered by SBHC, please call your child's school clinic during school hours at the number listed below.

Thank you.

Danbury High School SBHC, 43 Clapboard Ridge Road, Danbury, CT 06811 (203) 790-2886
Broadview Middle School SBHC, 72 Hospital Avenue, Danbury, CT 06810 (203) 731-8272
Rogers Park Middle School SBHC, 21 Memorial Drive, Danbury, CT 06810 (203) 778-7479

Connecticut Institute For Communities, Inc. (CIFC)
Greater Danbury Community Health Center (GDCHC)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE GREATER DANBURY COMMUNITY HEALTH CENTER ("GDCHC") MAY USE AND/OR DISCLOSE HEALTH INFORMATION ABOUT YOU, HOW YOU CAN ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

GDCHC's Commitment to Your Privacy

GDCHC is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain at GDCHC concerning your PHI. According to federal and state law, we must follow the terms of the Privacy Notice that we have in effect at the time. This Notice will take effect on August 1, 2013, and will remain in effect until it is amended or replaced by GDCHC.

GDCHC reserves the right to change its privacy practices as the law permits. GDCHC will amend this Notice to reflect any change(s) and make any new Notices available upon request. Any changes to our privacy practices will be effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of GDCHC's Notice of Privacy Practices at any time by contacting our Privacy & Security Officer, Diana Trumbley, at (203) 743-0100, or via mail at 57 North St., Suite 311, Danbury, CT 06810. You may also contact Ms. Trumbley with questions about this notice or to file a privacy/security complaint.

GDCHC WILL KEEP YOUR HEALTH INFORMATION CONFIDENTIAL, USING IT ONLY FOR THE FOLLOWING PURPOSES. PLEASE NOTE THAT THE FOLLOWING USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Treatment: While we are providing you with health care services, we may share your protected health information (PHI), including electronic protected health information (ePHI), with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, or data analysis. These business associates and subcontractors are required by Federal law to protect your health information. For example, we may ask you to have laboratory tests (such as blood or urine), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may disclose your PHI to a pharmacy when we order a prescription for you. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Additionally, everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your PHI to seek payment for services we provide to you. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatments. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, to evaluate the implementation of our compliance programs, and/or to conduct cost-management or business planning activities.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

NOTE: This is an abbreviated version of GDCHC's Notice of Privacy Practices. The full notice lists: (1) additional ways GDCHC may use your health information; (2) situations when your authorization is required for release; and (3) your rights regarding PHI. A full notice is available at all GDCHC sites. To receive a copy of the full and complete GDCHC Notice of Privacy Practices, please contact School Based Health Center Staff.

Registration # _____

Connecticut Institute for Communities, Inc. (CIFC) Greater Danbury Community Health Center (GDCHC)

School Based Health Centers Permission Form

All information on the front and back of this permission form must be completed, dated and signed before your child can receive services from the School Based Health Centers. If a student is 18 or older, he/she may sign his or her own permission form. Demographic information is required by the State and will be used for statistical purposes only.

Student Name (Last, First, M.I.)	Date of Birth (month/day/year)	☐ Male ☐ Female	Grade/Cluster
Street Address (Street, Town, State, ZIP code)		Home Phone Number	
Please Check School: ☐ Broadview Middle School ☐ Rogers Park Middle School ☐ Danbury High School/ACE ☐ Henry Abbott Technical High School		Student's Cell Phone Number	

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)	Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number	Work Phone Number

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)	Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number	Work Phone Number

Emergency Contact Name	Relationship to Student
Home Phone Number	Work Phone Number	Cell Phone Number

Demographic Information	Race: (Please check all that apply) ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ More than one race	
Is the student Hispanic/Latino? ☐ YES or ☐ NO	What language(s) does the student speak? (Please check all that apply) ☐ English ☐ Spanish ☐ Portuguese ☐ Other:_____	In what country was the student born?
Is the student on the free or reduced lunch program? ☐ YES or ☐ NO	Family Income Per Year	Family Size

Medical Care **Please provide a copy of insurance card		**Dental Care** **Please provide a copy of dental insurance card	
Name of Doctor or Medical Clinic:		Name of Dentist:	
Doctor's Address (Street, Town, State, ZIP)		Dentist's Address (Street, Town, State, ZIP)	
Doctor's Phone Number:	Date of last physical exam:	Dentist's Phone Number:	Date of last dental exam:

Does the student have **MEDICAID/Husky Insurance:** YES or NO
Medicaid Pending: YES or NO
****Please provide a copy of the insurance card**

If your child does not have health insurance
Please call 1-877-CT-HUSKY

Medicaid #: _____

Child's name on Card: _____

Does the student have **Private/Commercial Insurance:** YES or NO
****Please provide a copy of the insurance card**

Name of Insurance Company: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Address: _____
Policy Holder's Employer: _____
Relationship to student: _____
Insurance Number for the student: _____
Group number: _____

I have read the information regarding the CIFC GDCHC School Based Health Center and I give permission for this student to obtain all services offered at the School Based Health Center while he/she is enrolled in school. I understand that services are confidential, except in life-threatening situation or emergency services and accordance with the law. I give permission to the CIFC GDCHC School Based Health Centers and the Danbury Public Schools/ Henry Abbott Technical School to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing. I authorize payments to be made directly to the CIFC GDCHC School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the CIFC GDCHC's privacy policy as per federal law. **Unless I choose to withdraw my consent in writing, this authorization for services at the School Based Health Centers will continue for the entire period of time this student is enrolled in Danbury Public Schools/Henry Abbott Technical School.**

Date: _____ **Signature:** _____ **Relationship to student:** _____

SBHC Medical History Form

Student's Name: _____ Date of Birth: _____

Is the student currently taking any medications? If yes, please list medications and dose:

_____

_____

_____

Please check **"YES"** or **"NO."** Please explain all "YES" answers in the space provided.

Medical History:	**NO**	**YES**	**(If YES, please explain)**
Allergies (i.e. food, medication, chemicals, etc.)			
Any problems with vision (contacts/glasses)			
Any problems with hearing			
Concussion (when?)			
Fainting or blacking out			
Heart Problems/Murmurs/Chest Pain			
High Blood Pressure/Cholesterol			
Problems Breathing/Coughing/Asthma			
Blood Disease/Disorders (i.e. Anemia, Sickle Cell, etc.)			
History of Seizures			
Diabetes/Thyroid/Endocrine			
Hospitalization or Surgery			
Broken bones, dislocations, or other problems			
Muscle or joint injuries			
Neck or back injuries			
Running/exercise problems			
"Mono" (When?)			
TB or Positive skin test			
Dental Problems			
Headaches or Migraines			
Weight or Eating issues			
Has only one kidney or testicle or eye			
Females: Menstrual problems			
Other medical problems not addressed above:			

Mental Health History:	**NO**	**YES**	**(If YES, please explain)**
Anxiety			
Mood disorder/depression			
Loss/divorce issues			
ADHD/ADD/Learning Disorder			
Autism/Asperger's			
Eating disorder/weight problem			
Cutting/self-mutilation			
Smoking/Alcohol Use/Drugs			
Other mental health/behavioral problems:			

Family History:	**NO**	**YES**	**Relative (who?)**	**(If YES, please explain)**
Sudden unexplained death of a relative (under age 50)				
Family members with heart disease, high cholesterol and/or diabetes (which?)				
Alcohol/Drug Problems				
Mental Illness (i.e. Depression)				
Any other family medical problems not addressed above				
Any other family issues not addressed above				
Is the student under the care of any medical specialist (Explain)				

If you would like to speak with one of the School Based Health Center staff members regarding concerns you may have about your child, or for general SBHC questions, please call during school hours:

Broadview Middle School SBHC (203) 731-8274 Fax: (203) 731-8275
Rogers Park Middle School SBHC (203) 778-7479 Fax: (203) 778-7481
Danbury High School SBHC (203) 790-2886 Fax: (203) 797-4793
Henry Abbott Tech SBHC (203) 797-4460 x4936

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

Date: _____ **Signature:** _____ **Relationship to student:** _____