School-Based Health Center/Clinic

The North Canaan Board of Education (Board) endorses the placement of a School-Based Health Center/Clinic (SBHC). The SBHC model of health care consists of on-school-site health care delivery by an interdisciplinary team of health professionals, which can include primary care and mental health clinicians. The staff, consisting of a nurse practitioner, clinical social worker and medical assistant, shall work in cooperation with the school staff and community providers.

The mission of the SBHC is to promote the well-being and development of children and their families by giving priority to the unmet needs of children lacking physical, emotional, and intellectual care and nurturing.

Definitions

A **"School-Based Health Center"** means a health center that is located in or on the grounds of a school facility of a school district, school Board, Indian tribe, or tribal organization; is organized through school, community, and health provider relationships; is administered by a sponsoring facility (e.g. hospital, health department, community health center, or nonprofit health or human services agency); and provides comprehensive on-site medical and behavioral health services to children and adolescents according to state and local law.

An **"Expanded School-Based Health Center"** is defined the same as a school-based health center except that it may provide either medical or behavioral services that include, but are not limited to dental services, counseling, health education, health screening, and prevention services, according to state and local law.

A **"Sponsoring Agency"** for a school-based health facility means a hospital, public health department, community health center, nonprofit health or human services agency, school or school system, or program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian Tribe or a tribal organization.

The placement of a school-based health center/clinic in North Canaan Elementary School offers the convenience of having children/adolescents receive health care at the school, eliminating barriers to such care such as transportation, and the lack of available or convenient appointments with their PCPs. The Board supports the goal of the SBHC to provide the health care that allows the child/adolescent to maximize their school experience and improve attendance rates. The SBHC, licensed by the Department of Public Health, is not the same as the school nurse's office. However, the SBHC staff and school nurse will work together to provide coordinated, comprehensive health services to students.

The School-Based Health Center:

- Is a fully licensed primary care facility providing a range of physical and mental health services, located within the school;
- Operates in compliance with the regulations of the Department of Public Health's established minimum quality standards;

- Combines medical care and counseling along with health education that reinforces a healthy lifestyle;
- Provides additional services that work in collaboration with doctors and mental health providers in the community and is not intended to replace the family's primary care provider;
- Directs its services at, but not limited to, students who do not have access to a family doctor or whose families have little or no health insurance; and
- Provides services at no out-of-pocket costs to the family.

The medical and mental health services provided at the SBHC located in District schools shall include, but are not limited to, the following:

- Diagnosis and treatment of acute and chronic illnesses;
- Physical examinations;
- Immunizations;
- Health education (nutrition, fitness) including presentation to classes; and
- Individual, group and family counseling (anxiety, depression, peer and family relationships, academic issues, behavioral problems, eating disorders etc.)

In order to access the services of the SBHC, the student's parent/guardian must sign the School-Based Health Centers Permission Form (Form #2) and complete the Medical History form (Form #3). Services will not be provided to students unless these requirements are fulfilled. All students enrolled at the school site may use the SBHC regardless of income or health care coverage.

The confidentiality of all health information that identifies students and the treatment and services provided to them shall be maintained separately from academic records. School Staff shall not have access to medical records of students maintained at the SBHC unless written permission is given by a student's parent or legal guardian. (See Form #1-Notice of Privacy Practices)

(cf. 5125.11 – Health/Medical Records HIPAA)
(cf. 5141 – Student Health Services)
(cf. 5141.21 – Administering Medication)
(cf. 5141.22 – Communicable/Infectious Diseases)
(cf. 5141.25 – Students with Special Health Care Needs/Food Allergy)
(cf. 5141.3 – Health Assessments and School Programs)
(cf. 5141.4 – Child Abuse and Neglect)
(cf. 5141.5 – Suicide Prevention)
(cf. 6142.1 – Family Life and Sex Education)

Legal Reference: Connecticut General Statutes
10-203 Sanitation.
10-204a Required immunizations.
10-204c Immunity from liability.
10-205 Appointment of school medical advisors.
10-206 Health assessments, as amended by PA 07-58 and PA 11-179.
10-206a Free health assessments.

10-207 Duties of medical advisers, as amended by P.A. 12-198.
10-208 Exemption from examination or treatment.
10-209 Records not to be public.
10-210 Notice of disease to be given to the parent or guardian.
10-212 School nurses and nurse practitioners.
10-212a Administration of medicines by school personnel.
10-214 Vision, audiometric and postural screening: When required; notification of parents regarding defects; record of 10-217a Health services for children in private nonprofit schools. Payments from the state, towns in which children reside and private nonprofit schools.

19a-630 (10) Definitions. "Health Care Facilities."

38a-472e Health insurer. Requirements regarding an offer to contract with a school-based health care center.

Department of Public Health, Public Health Code – 10-204a-2a, 10-204a-3a and 10-204a-4.

PA 15-59 An Act concerning School-Based Health Centers.

Federal Family Educational Rights and Privacy Act of 1974 (section 438 of the General Education Provisions Act, as amended, added by section 513 of P.L. 93-568, codified at 20 U.S.C. 1232g).

42 U.S.C. 1320d-1320d-8, P.L. 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Adopted: March 12, 2024

NORTH CANAAN BOARD OF EDUCATION
North Canaan, Connecticut

5141.29
Form #1

Notice of Privacy Practices

Community Health & Wellness
Our Family – Taking Care of Yours

Authorization to Treat – Assignment of Benefits – Notice of Privacy Practices

- I hereby consent to being treated as a patient of Community Health & Wellness Center of GreaterTorrington, Inc. (CHWCGT) at any CHWCGT location, including school-based locations when applicable, for the purpose of receiving medical, behavioral health or dental care and treatment and/or diagnostic procedures. I understand I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that a discussion of the risks, benefits and alternatives to each procedure or treatment will be available to me prior to each procedure or treatment.
- I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by CHWCGT and any third-party establishment necessary to perform business activities.
- I hereby authorize and direct my insurance carrier to make the payment of any benefits due directly to CHWCGT, and I understand any co-pays, referrals, new insurance information, deductibles and denied services will be the patient's responsibility as applicable. Copays will not be collected in our school-based programs.
- I understand my patient responsibility regarding payment for the services I receive from CHWCGT, and agree to provide new or updated insurance information as needed.
- CHWCGT is not responsible for any services I may receive at other facilities, which are not owned and operated by CHWCGT. Any charges from such facilities are the responsibility of the patient. For example: lab, x-rays, specialty care, etc.
- I acknowledge that I have received a copy of CHWCGT Notice of Privacy Practices that describes how medical information about me may be used and disclosed. I understand that I am entitled to updates to these Privacy Practices, and if I have any questions or complaints, I may contact the CHWCGT Privacy Officer.
- I understand CHWCGT may access my medical information, including diagnostic and screening results, from other care providers' electronic health record systems in order to provide treatment. • I hereby consent to allow CHWCGT to retrieve information from a database that monitors when and who last prescribed medications to me.
- I understand that CHWCGT participates in health information exchange to enhance the quality of care provided to me. I acknowledge that I may opt out of information exchange at any time.
- As required by law, CHWCGT will share immunization information with the State of CT Department of Public Health (DPH). I understand I can opt out of this by sending a signed written request to the DPH Immunization Program.
- I have received a copy of my patient rights and responsibilities and understand my rights and responsibilities as a patient.

Patient Printed Name: _____
Birthday: ____/_____/_____
Patient Signature: _____
Date: ____/_____/_____
Guardian/POA/Parent/Conservator signature, if applicable:_____
_____ HIPPA given on Date: ___/____/____

SCHOOL-BASED HEALTH CENTERS
Consent for Services Information

WHAT IS A SCHOOL-BASED HEALTH CENTER? A comprehensive, primary health care center located in a school. Staff include: medical providers such as nurse practitioners, physician assistants, pediatricians, dentists, dental hygienists, dental assistants, medical assistants and social workers.

WHAT DO SCHOOL-BASED HEALTH CENTERS DO? School-Based Health Centers provide a limited variety of services, including physical exams; health care services for students who are sick (co-management with a child's primary care provider on most health related issues) including asthma and diabetes; immunization updates; individual, group and family counseling, parent guidance; classroom education on wellness issues; crisis intervention; dental care services including cleanings, fillings, and extractions. Referrals are made to community providers as needed.

HOW CAN A STUDENT USE THE HEALTH CENTER? A student must have a consent form signed by his/her parent or guardian in order to receive health center services. If the student is 18 years old or older or emancipated, he/she can sign his/her own Consent for Services form. Each year the School-Based Health Centers will send home the Consent for Services form in order for your child to remain an active member of the School-Based Health Centers.

HOW ARE THE SERVICES PAID FOR? A sponsoring facility Center and the State of Connecticut contribute funds for the operation of these health centers. Billing of third party insurers will assist us in covering the costs of operating the School-Based Health Centers. **You or your child will not be charged directly for any services**. Students and families without any insurance coverage will not be charged.

The School-Based Health Centers will not be billing parents or students directly for any co-payments required by your insurance, we will not seek payment from you if you have not met your insurance company's deductibles, and will not seek direct payment from you if the claim we submit to an insurance company for services provided is denied by the insurance company. Our billing should not have any impact on the premiums you pay.

CONFIDENTIALITY: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. The School-Based Health Centers may release information regarding your child and/or services provided in order to bill third party payers including private insurance and Medicaid for services, and for healthcare operations and treatments. Please review the Notice of Privacy Practices, which outlines how we may use and disclose your child's protected health information.

SCHOOL-BASED HEALTH CENTERS
Consent for Services Information

The Board of Education maintains a partnership to ensure access to health care for all students. By operating health centers on school grounds, the School-Based Health Centers accept a unique responsibility to promote a safe and healthy environment for all students. School-Based Health Centers staff will cooperate and communicate with you, the Board of Education staff, whenever student behavior/or health may result in risk of harm to the student or others within the educational setting. The health center staff will follow established protocols and policies developed by the School-Based Health Centers as well as those detailed in the Board of Education's Staff Manual and Student Handbook. Completing and signing the Consent for Services form authorizes us to release information as identified in the attached Notice of Privacy.

If you have any general questions regarding the School-Based Health Centers, please call the School-Based Health Center directly. We encourage you to complete and sign the Consent for Services and Medical History forms in order for our staff to further assist you and your child.

SCHOOL-BASED HEALTH CENTERS CONSENT FOR SERVICES

Please complete all information on the front and back of this permission form in ink; all questions must be answered. You must sign and date it in order for your child to receive services from the School-Based Health Centers. If this form is not fully completed, your child will not be able to receive services unless it is an emergency. If you need help filling out the form, please contact the School-Based Health Center. If a student is 18 or older or emancipated, s/he can sign her/his own permission form.

Student's name: _____ ☐ Female ☐ Male
Last First Middle
Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Social Security No.: _____

Cell Phone (of student): _____ Email address: _____

School: _____ Grade: _____ Homeroom #: _____

Mother/Father or Guardian Name: _____ **Mother/Father or Guardian Work Phone:** _____

Parent/Guardian Beeper/Cellular Phone #s: _____ **Parent Date of Birth:** _____

Emergency contact (please note how the person is related to the student):

Contact Name: _____ Phone/Cellular # _____ Relationship _____
Contact Name: _____ Phone/Cellular # _____ Relationship _____

Ethnicity of Student:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown/Not Reported ☐ Declined to Specify ☐ Other

Racial/Ethnic Background of Student:

☐ American Indian or Alaska Native ☐ Black/African American ☐ Pacific Islander ☐ Unreported/Refused
☐ Asian ☐ Native Hawaiian ☐ White ☐ Other

Source of Medical Care:

Who is your child's Doctor/Clinic: _____ Address & Phone: _____
Dentist/Clinic: _____ Address & Phone: _____

Where do you get your child's medical care?

☐ Community Health Center ☐ No Regular Source ☐ Urgent Care Clinic
☐ Emergency Room ☐ Private Doctor ☐ Unknown
☐ Hospital Clinic School ☐ Based Health Center ☐ Other Type

CONTINUE ON NEXT PAGE

FOR OFFICE USE ONLY:

Consent Date: _____ **SBHC Chart #**: _____ **Date Registered:** _____
Date Chart Opened: _____

Student Grade Information:

Year	_____	_____	_____
Age	_____	_____	_____
Grade	_____	_____	_____
Homeroom	_____	_____	_____

Address Updates:

_____
_____
_____

Phone Updates:

_____
_____
_____

SCHOOL BASED HEALTH CENTER STUDENT INSURANCE INFORMATION

*****IMPORTANT*** Please provide information regarding your child's Managed Care Company, Private Insurance and/or Dental coverage. Form will be returned if insurance information is not filled in.**

Type of Insurance (check all that apply and complete information below on your child's insurance coverage)
☐ **Medicaid (Title 19)** ☐ **Private/Commercial Insurance** ☐ **Dental** ☐ **No Insurance Coverage**
☐ **Medicaid HUSKY A** ☐ **Medicaid HUSKY B**

MEDICAID (TITLE 19); Medicaid HUSKY A; Medicaid HUSKY B Information:
Child's Medicaid #: _____ Name of Managed Care Company: _____
Child's managed care doctor: _____ Effective Date: _____

PRIMARY INSURANCE INFORMATION:
Policy Holder's Name: _____ Relationship to Student: _____
Policy Holder's Address: _____ Policy Holder's Date of Birth: _____
Policy Holder's Social Security #: _____
Insurance Carrier Name and Address: _____
Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____
Effective Date of Coverage: _____
Policy Holder's Employer Name and Address: _____

DENTAL INSURANCE INFORMATION:
Policy Holder's Name: _____ Relationship to Student: _____
Policy Holder's Address: _____
Policy Holder's Date of Birth _____ Policy Holder's Social Security #: _____
Plan Name: _____ Plan #: _____
Is the Student covered by another dental plan? ☐ Yes ☐ No
If yes, name of plan and address: _____ Plan #: _____

Please provide a copy of your current insurance card(s), Medicaid card, Medicaid Managed Care Plan Card and any claim forms(s) your insurance carrier requires.

Please list the names of other children living in your home; if they attend school please list the school and grade:

_____ _____
_____ _____

I have received the materials regarding the services of the School Based Health Center SBHC including the SBHC Notice of Privacy Practice. In accordance with the State Statute, (Conn. Gen. Stat. 19a-602), by signing this consent form I agree that my child can discuss and receive the above-noted services. I give permission to the School Based Health Centers to release information regarding treatment and/or services to my or my child's insurance provider(s) for the purpose of billing. I authorize payments to be made directly to the School Based Health Centers for services provided.

***Please note: If you do not have insurance at the time you sign this consent, but obtain it later, we will bill your insurance company for services provided using your signature below as authorization to bill.**

Parent/Guardian Signature: _____ Date: _____

Relationship to Child: _____ School Year: _____

5141.29
Form #3

STUDENT'S MEDICAL HISTORY

Student Name:_____ **Birth Date:** _____

PAST MEDICAL HISTORY: (please fill in and explain)

Has your child had any medical problems: _____

1. Chronic problems (asthma, diabetes, ADHD, Mental Health, etc. _____
2. Disabilities (special ed./medical etc.) _____
3. Has your child ever been hospitalized/had surgery/been injured: _____
4. Childhood illness: (Chicken pox, measles, mumps, rubella, etc.) _____

Has your child had any of the following: (Please check either "Yes" or "No" for **every** question; if you cannot answer a question please attach a statement explaining why.

Yes	No		Yes	No	
☐	☐	Eating	☐	☐	Problems Pregnant
☐	☐	HIV/AIDS	☐	☐	Seasonal Allergies
☐	☐	Sleeping Problems	☐	☐	Arthritis
☐	☐	Weight Problems	☐	☐	Headaches
☐	☐	Vision Problems	☐	☐	Seizures
☐	☐	Hearing Problems	☐	☐	Blood Disorders (Anemia, Sickle Cell Disease or Trait)
☐	☐	Dental Problems	☐	☐	Clotting Disorders
☐	☐	Skin Disorders (Eczema, Psoriasis)	☐	☐	Attention Deficit Disorder or ADHD
☐	☐	Ear Infections	☐	☐	Depression
☐	☐	Asthma	☐	☐	Mental Illness
☐	☐	Pneumonia	☐	☐	Hernia
☐	☐	Tuberculosis (Contact/Infection)	☐	☐	Diabetes
☐	☐	Heart Problems (Murmur, Rheumatic, Heart Disease)	☐	☐	Thyroid Problems
☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	High Cholesterol	☐	☐	Chicken Pox
☐	☐	Stomach Problems (Diarrhea, Constipation, Pain, Vomiting)	☐	☐	Mononucleosis
☐	☐	Urinary Tract Infections	☐	☐	Hepatitis
☐	☐	Menstrual Problems	☐	☐	Meningitis
☐	☐	Lead / Highest Level _____	☐	☐	Other: Explain: _____

Is your child taking any medications on an everyday or frequent basis? ☐ Yes ☐ No Explain: _____

Medications can include some of the following: (Please list names)

Yes	No	
☐	☐	Aspirin, Ibuprofen or Tylenol? _____
☐	☐	Oral Contraceptive/Birth Control pills? _____
☐	☐	Antibiotics such as Penicillin, etc.? _____
☐	☐	Mental health or behavioral medications (i.e., ADHD)? _____
☐	☐	Vitamins (including iron pills)? _____
☐	☐	Asthma medication? _____
☐	☐	Allergy medication? _____
☐	☐	TB medication? _____
☐	☐	Diabetic medications (i.e., insulin)? _____
☐	☐	Other medication? _____

Is your child allergic to or have they had an adverse reaction to:

☐ Yes	☐ No	Betadine or iodine	☐ Yes	☐ No	Local Anesthesia (Novocain, etc.)?
☐ Yes	☐ No	Penicillin or other antibiotics?	☐ Yes	☐ No	Latex or Rubber products?
☐ Yes	☐ No	Sedatives, Barbiturates?	☐ Yes	☐ No	Codeine or other pain killers?
☐ Yes	☐ No	Aspirin or Ibuprofen?	☐ Yes	☐ No	Other_____

Other allergies or reactions? (include allergies to foods, insects, animals, etc.) Please list**:** _____

STUDENT MEDICAL HISTORY

Please list any concerns you have regarding your child's physical or mental health: _____

_____

DENTAL HISTORY

Name of Dentist: _____ Child's last dental visit: _____

Do you have any concerns about your child's teeth? _____

Has your child ever had anesthesia (Novocain, Laughing Gas) for dental work? _____

Any problems with anesthesia? _____

(If you have a private dentist, SBHC dentists will only see your child in an EMERGENCY).

If you do not have your own dentist, do you want your child to see the SBHC Dentist? ☐ Yes ☐ No

FAMILY HEALTH HISTORY:

Please check below if any of your child's **BLOOD RELATIVES** (i.e. parents, brothers/sisters, aunts, uncles, grandparents) have had any of the following illnesses and note which relative had them:

Yes	No	Illness	Relative	Explain
☐	☐	Diabetes, Endocrine Disorder (thyroid)		
☐	☐	Cancer		
☐	☐	Heart problem, Stroke		
☐	☐	High Blood Pressure		
☐	☐	Blood Disorders including Anemia		
☐	☐	Clotting Disorders		
☐	☐	Respiratory Problems including Asthma		
☐	☐	Mental Illness (i.e. Depression)		
☐	☐	Alcohol/Drug Problems		
☐	☐	Infections (TB/HIV/AIDS)		
☐	☐	Death under the age of 50		
☐	☐	OTHER: _____		

I have read the materials regarding School Based Health Centers (SBHC) services and received the SBHC Privacy Notice and give my permission for my child to receive SBHC services. This medical history is accurate to the best of my knowledge. I understand I should inform the SBHC staff if there are any changes in my child's mental or physical health.

I give permission for the exchange of relevant medical/mental health information amongst SBHC staff, with North Canaan Board of Education staff, and with outside providers on an as needed basis based upon the Privacy Notice unless I object in writing. The goal of this process will be to assist in maintaining health and safety in the schools, and to coordinate my child's care. SBHC charts may be transferred to other SBHC clinics and the Community Based Health Center in North Canaan as needed. I understand this authorization automatically expires two academic school years from the date signed unless I withdraw my consent in writing.

Signature: _____ **Date:** _____

Relationship: _____