School-Based Health Center

Dickinson Middle School
1801 Milltown Road
Wilmington, Delaware 19808
Phone: (302)892-3270 Fax: (302)892-3274

REGISTRATION FOR 11 YEAR OLDS ONLY

Dear Parents/Guardians:

The Dickinson School-Based Health Center (SBHC) is a partnership between Christiana Care Health Services and Red Clay School District and the Delaware Division of Public Health. 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 needed 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 Dickinson School-Based Health Center at (302) 892-3270.**

SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES
Dickinson 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 **Dickinson** 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.

TELEHEALTH

2. ***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 my provider.

3. ***I understand*** that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.

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

5. ***I understand*** that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. In the event of a technical failure, I understand that I should immediately contact my provider's office, or, if it is an emergency, dial 911.

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

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

8. ***I consent*** to have ChristianaCare obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.

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

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

11. ***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.

12. ***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.

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

14. ***I agree*** that all information provided on the registration Health History Form and this consent is accurate and complete.

15. 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 (*in pen*)				**Grade: 6 7 8**
Patient's Last Name:	**First:**		**Middle:**	
Identified Sex: ☐ **Male** ☐ **Female** ☐ **Transgender Male** ☐ **Transgender Female** ☐**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*

Source of payment for care, please check off one of the following: **_____No Insurance** **_____Medicaid Provider: _____** **Medicaid Number: _____** **_____Commercial Insurance : _____** **Policy Number: _____** **Subscriber Name: _____** **Relationship to Student: _____** **Subscriber Birthdate: _____** **_____Delaware Healthy Children Program**	***Secondary Insurance Information:*** **_____Medicaid Provider: _____** **Medicaid Number: _____** **_____Commercial Insurance: _____** **Policy Number: _____** **Subscriber Name: _____** **Relationship to Student: _____** **Subscriber Birthdate: _____**

Christiana Care Health System School-Based Health Center
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:

☐ 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 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.

☐ ADHD/learning disability_____	☐ Headaches _____	☐ Sickle Cell_____
☐ Alcoholism/Drug Abuse_____	☐ Heart Disease_____	☐ Stroke_____
☐ Anemia _____	☐ Hemophilia _____	☐ Thyroid Disease_____
☐ Arthritis _____	☐ Hepatitis _____	☐ Tuberculosis_____
☐ Asthma_____	☐ High Blood Pressure _____	☐ Unexplained Death_____
☐ Birth defects_____	☐ High Cholesterol _____	☐ Other_____
☐ Cancer_____	☐ Kidney/Bladder Disease_____	
☐ Cystic Fibrosis_____	☐ Mental Illness_____	
☐ Deafness _____	☐ Obesity _____	
☐ Diabetes _____	☐ 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.

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.