# Howard County School-Based Wellness Centers

*"Bringing your child quality health care in school"*

A partnership between the Howard County Health Department
and the Howard County Public School System

**Bollman Bridge Elementary School**
8200 Savage Guilford Road
Jessup, MD 20794

**Patuxent Valley Middle School**
9151 Vollmerhausen Road
Jessup, MD 20794

**ALL** students attending the Bollman Bridge Elementary and Patuxent Valley Middle Schools are eligible to enroll in the Wellness Center Program.

Our Nurse Practitioner can provide the following services:

- Assessment, diagnosis and treatment of acute illness and injuries, including prescriptions if needed
- Preventive care including physical exams, immunizations, health screenings and education
- Management of obesity, asthma, and other stable chronic illnesses

Advantages to enrolling your child in the Wellness Center Program:

- Our staff works directly with the school nurse, guidance staff and administration to limit the amount of time your child misses from class.
- Children can receive health care *during* the school day and if ill, the provider will determine if they are well enough to remain in school, which also means parents don't have to leave work unnecessarily.
- If a staff member is unable to reach you, your student will be given the care normally provided by school health staff instead of school-based wellness services, unless you have provided additional consent on the enrollment form for your child to receive health care from the school-based wellness center without the staff talking to you.
- The child's primary care provider in the community is always notified by a letter or phone call of visits to the Wellness Center to ensure continuity of care.

Cost for School-Based Wellness Center Services:

- You will NOT be charged by the Health Department or your insurance company. **There is no co-pay or deductible.** If your child has Medical Assistance, it will be billed directly.
- If your child is uninsured, families will be assisted in applying for Maryland's Children's Health Program (MCHP), if eligible. MCHP provides health care coverage to low-income children up to age 19 and pregnant women of any age.

If you would like your child to be enrolled in the Wellness Center, please return your **completed** enrollment form to the health suite at your child's school. **Services can only be provided to students who are enrolled.**

If you have any questions or would like to schedule an appointment, please call **301-490-1655**.
Wellness Centers are open **Monday-Friday 8 a.m. - 4 p.m. during the school year**.

# HOWARD COUNTY HEALTH DEPARTMENT
# SCHOOL-BASED WELLNESS CENTER PROGRAM
## Parent/ Guardian Consent Form

## STUDENT INFORMATION

**Last Name**: _____

**First Name**: _____

**Address**: _____

_____
*City* *State* *Zip Code*

**Date of Birth**: _____/_____/_____
*Month* *Day* *Year*

**Sex**: ❑ Male ❑ Female

❑ Transgender Male ❑ Transgender Female

❑ Non-Binary_____

**Social Security Number (optional): _____**

**Race / Ethnicity**: ❑ Hispanic ❑ Black ❑ White

❑ Native American ❑ Asian/Pacific Islander

❑ Other _____

**Preferred Language**: _____

**Name of School:** _____

**Grade:** _____

## PARENT/GUARDIAN INFORMATION

**Mother**
Last Name: _____First Name:_____

Contact Number(s): _____

E-mail Address: _____

**Father**
Last Name: _____ First Name:_____

Contact Number(s): _____

E-mail Address: _____

**Legal Guardian, If Applicable**

Last Name: _____First Name:_____
Relationship of legal guardian to student:
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Number(s): _____

E-mail address: _____

**Additional Emergency Contact**

Name: _____

Relationship to Student: _____

Contact Number(s):_____

## HEALTH INSURANCE INFORMATION

**Does your child have Medical Assistance?** ❑ No ❑ Yes **Private Insurance?** ❑ No ❑ Yes **No Insurance?** ❑ No ❑ Yes

If Medical Assistance, please provide the following information**.** **Medical Assistance #**_____ and

**Patient ID #** _____

**Which health insurer does your child receive health services through? Please check the appropriate box below:**
❑ AMERIGROUP ❑ Maryland Physicians Care ❑ Riverside ❑ Jai ❑ Medstar ❑ United Healthcare-Community Plan

❑ Kaiser Permanente ❑ Priority Partners

**If your child does not have health insurance, would you like the Howard County Health Department staff contact and assist you with applying for health insurance?** ❑ No ❑ Yes

**Please turn this page over, read, sign and date on the two designated lines.**
**Thank you!**

**IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.**

# HOWARD COUNTY HEALTH DEPARTMENT
# SCHOOL-BASED WELLNESS CENTER PROGRAM
## Parental Consent Form

**Child's Name:** **School:**

### SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Howard County Health Department School Based Wellness Center. School-Based Wellness Center services may include, but are not limited to:

- Health screening and comprehensive physical examinations (complete medical examination) including those for EPSDT, school and sports
- Medically prescribed, basic laboratory tests which may include venipuncture and testing of other body fluids, such as urine or throat and wound secretions, for conditions including anemia, strep throat, and diabetes
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
- Mental health services including evaluation, diagnosis, treatment, and referrals, if provided at Wellness Center
- Referrals for service not provided at the school-based wellness center
- Annual health questionnaire/survey and health education and risk preventions counseling

**X**_____ _____

**Signature of Parent/Guardian** **Date**

### HOWARD COUNTY HEALTH DEPARTMENT'S
### FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
### HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my child to release any medical or other information to assist in the management of my child's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information and that I can change my mind at any time and revoke my authorization by writing to the School-Based Wellness Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

**I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:**

**Information Required by Law or School System:**
- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

**Information to Protect Health and Safety**:
- Conditions which may require emergency medical treatment
- Mental health conditions including evaluations, diagnosis, treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity
- Health insurance coverage

**PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:**
I, the undersigned, voluntarily consent to treatment of my child by the provider and staff of the Howard County Health Department School Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I authorize payment directly to the HCHD for services for which HCHD accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

**X**_____ _____

**Signature of Parent/Guardian** **Date**

Time Period During Which Release of Information is Authorized:
**From**: Date that form is signed **To**: Date that student is no longer enrolled in the School-Based Wellness Center

By signing below, I am granting permission for my child to have a School Based Wellness Center visit even if the school nurse is unable to contact me at the time of the visit.

**X**_____ _____

**Signature of Parent/Guardian** **Date**

**IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.**

# HOWARD COUNTY HEALTH DEPARTMENT
# SCHOOL-BASED WELLNESS CENTERS PROGRAM
## Medical and Family History Questionnaire

| Child's Name: | Today's Date: |
|---|---|

**FAMILY HEALTH INFORMATION**

**Does any of the child's family members (parents, sisters, brothers, grandparents)have or had the following:**

| Health Problem | Yes | No | Which Family Member? |
|---|---|---|---|
| Asthma | | | |
| Diabetes | | | |
| Mental Health/ Psychiatric Problem | | | |
| Sickle Cell | | | |
| Other: | | | |

**Who is the student's regular health provider?**

**Name:** _____ **Office Telephone:** (  ) -

**Address:** _____

**When was your child's last physical or well child exam?** _____
**Date/Month**

**Please provide the name and phone number of your pharmacy.**
**Name:** _____ **Phone Number:** (  ) -

**CHILD'S HEALTH INFORMATION**

**Please place a check in the box for any health problems your child has had.**

- ☐ **Asthma** ☐ **Attention Deficit Disorder** ☐ **Bleeding Problems** ☐ **Depression**
- ☐ **Diabetes** ☐ **Ear Infection** (frequent) ☐ **Epilepsy/Seizures** ☐ **Headache** (frequent)
- ☐ **Hearing** ☐ **Heart Problems/Murmur** ☐ **Rheumatic Fever** ☐ **Sickle Cell Anemia**
- ☐ **Tuberculosis** ☐ **Vision** ☐ **Other:** _____
- ☐ **Allergies (List all, including medicines):**

**If your child has been hospitalized, please provide the date(s) and reason(s):**

**PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES:** _____

_____

# MARYLAND DEPARTMENT OF HEALTH
# AND YOUR HEALTH INFORMATION

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

### Introduction

The Maryland Department of Health (MDH) is committed to protecting your health information. MDH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your health care, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. MDH and its Business Associates are required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any MDH agency. It is also posted on our website at https://health.maryland.gov/pages/index.aspx

### Permitted Uses & Disclosures

MDH employees will only use your health information when doing their jobs. For uses beyond what MDH normally does, MDH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions. The following are some examples of our possible uses and disclosures of your health information:

**Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:**

- **For treatment:** MDH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, MDH health care providers may need to review your treatment with your health care provider for medical necessity or for coordination of care.
- **To obtain payment:** MDH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** MDH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

**Other Uses and Disclosures of Health Information Required or Permitted by Law:**

- **Information purposes:** Unless you provide us with alternative instructions, MDH may send appointment reminders and other materials about the program to your home.
- **Required by law:** MDH may disclose health information when a law requires us to do so.
- **Public health activities:** MDH may disclose health information when MDH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.
- **Health oversight activities:** MDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** MDH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes**: In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, MDH may disclose health information to assist medical research.

- **Avert threat to the health or safety:** In order to avoid a serious and imminent threat to health or safety, MDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** MDH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. MDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** MDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **Family, friends, or others involved in your care:** MDH may share your health information with people as it is directly related to their involvement in your care or payment of your care. MDH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** MDH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** MDH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a MDH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, MDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** MDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** MDH may conduct the above-described activities ourselves, or we may use non-MDH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** MDH may use information about you to contact you in an effort to raise money for MDH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at MDH.

## Your Rights

**You Have a Right to:**

- **Request restrictions:** You have the right to request a restriction or limitation on the health information MDH uses or discloses about you. MDH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, MDH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that MDH send you information at an alternative address or by alternative means. MDH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the PHI. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If MDH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that MDH correct or add to your health record. MDH will respond to your request within 60 days, with up to a 30-day extension, if needed. MDH may deny the request if MDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If MDH approves the request for amendment, MDH will change the

health information and inform you, and MDH will tell others that need to know about the change in the health information.

- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, MDH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year. Additionally, MDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to opt-out of a MDH facility's patient directory, and you have the right to opt-out of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System for our Patients (CRISP).
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information**: If any of MDH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, MDH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

**For More information:**
This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact **Antigone Vickery, Deputy Health Officer, Howard County Health Department at 410-313-6300.**

**To Report a Problem about our Privacy Practices:**
If you believe that your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Maryland Department of Health, Division of Corporate Compliance at 1-866-770-7175.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. You may call the Maryland Department of Health for the contact information.

MDH will take no retaliatory action against you if you make such complaints.
**Effective Date:** This notice is effective on July 1, 2017.

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**(Provider programs must ensure that they try to get this acknowledgement signed)**
Acknowledgement of receipt of this notice:

Patient or Authorized Representative _____ Date _____

If unable to get acknowledgement, specify why: _____

Signature of MDH representative _____