Howard County
Health Department

HOWARD COUNTY
PUBLIC SCHOOL SYSTEM

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 Salvage 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

Both centers provide on-site mental health services provided by a licensed mental health provider.

There are many 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 be seen *during* school to determine if they have an acute illness or if they can remain in school, which also means parents don't have to leave work unnecessarily.
- Parents and the child's primary care provider in the community are always notified by letter or phone call of visits to the Wellness Center to ensure continuity of care.

Your 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, they will be billed directly.
- If your child is uninsured, families will be assisted in applying for Maryland's Children's Health Program (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 Wellness Center office 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. The Wellness Centers are open Monday-Friday 8 am-4 pm 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

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 MENTAL HYGIENE 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.

Safeguarding Your Protected Health Information
The Maryland Department of Health and Mental Hygiene (DHMH) is committed to protecting your health information. In order to provide treatment or to pay for your healthcare, DHMH 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. DHMH is required to follow the privacy practices described in this Notice, although DHMH 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 DHMH agency. It is also posted on our website at http://www.dhmh.state.md.us/.

How DHMH May Use and Disclose Your Protected Health Information
DHMH employees will only use your health information when doing their jobs. For uses beyond what DHMH normally does, DHMH must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of your health information.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:

For treatment: DHMH may use or share your health information to approve, deny treatment and to determine if your medical treatment is appropriate. For example, DHMH health care providers may need to review your treatment plan with your healthcare provider for medical necessity or for coordination of care.

To obtain payment: DHMH 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: DHMH 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 allowed by law:

Information purposes: Unless you provide us with alternative instructions, DHMH may send appointment reminders and other materials about the program to your home.

Required by law: DHMH may disclose health information when a law requires us to do so.

Public health activities: DHMH may disclose health information when DHMH is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

Health oversight activities: DHMH 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: DHMH 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 supervision of our Institutional Review Board or other designated privacy board, DHMH may disclose health information to assist medical research.

Avert threat to health or safety: In order to avoid a serious threat to health or safety, DHMH 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: DHMH will disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. DHMH 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: DHMH 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.

Families, friends or others involved in your care: DHMH may share your health information with people as it is directly related to their involvement in your care or payment of your care. DHMH may also share health information with people to notify them about your location, general condition, or death.

Worker's Compensation: DHMH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

Patient Directories: The health plan under which you are enrolled does not maintain a directory for disclosure to callers or visitors who ask for you by name. You will not be identified to an unknown caller or visitor without authorization.

Lawsuits, Disputes and Claims: If you are involved in a lawsuit, a dispute, or a claim, DHMH may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.

Law Enforcement: DHMH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.

You **have a Right to:**

Request restrictions: You have a right to request a restriction or limitation on the health information DHMH uses or discloses about you. DHMH will accommodate your request if possible, but is not legally required to agree to the requested restriction. If DHMH agrees to a restriction, DHMH will follow it except in emergency situations.

Request Confidential Communications: You have the right to ask that DHMH send you information at an alternative address or by alternative means. DHMH must agree to your request as long as it is reasonably easy for us to do so.

Inspect and copy: 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 fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

Request amendment: You may request in writing that DHMH correct or add to your health record. DHMH may deny the request if DHMH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. If DHMH approves the request for amendment, DHMH will change the health information and inform you, and will tell others that need to know about the change in the health information.

Accounting of disclosures: You have a right to request a list of the disclosures made of your health information after April 14, 2003. Exceptions are health information that has been used for treatment, payment, and operations. In addition, DHMH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officials or correctional facilities. There will be no charge for up to one such list each year.

Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

For More Information

This document is available in other languages and alternate 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 – 410-313-6300.**

To Report a Problem about our Privacy Practices

If you are a resident of a DHMH facility and believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Department of Health and Mental Hygiene, Resident Grievance System Central Office at 1-800-RGS-7454.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

DHMH will take no retaliatory action against you if you make such complaints.

Effective Date: This notice is effective on April 14, 2003.

(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 DHMH representative