Dear Parent or Guardian:

We are happy to inform you that Andrew Hill High School has a School-Based Health Center (SBHC). The SBHC is run by Bay Area Community Health (BACH) and is staffed by BACH medical and mental health professionals.

Please know that your child can use the School-Based Health Center and see your other doctors as well. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their primary doctor.

At the School-Based Health Center, your child can receive the services listed below at low or no cost to you, regardless of insurance status. The SBHC is allowed to bill insurance, however, for most services, there are no co-pays for you, and you do not receive a bill.

School-Based Health Center Services include:

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions
- Dental care
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Health Education and Counseling

To register your child for our School-Based Health Center services, please read and sign and return the Parental Consent form.

We look forward to meeting you and we look forward to providing health services to your child. Feel free to visit us at the School-Based Health Center or call us at 408-347-4240 for more information.

Sincerely,

Bay Area Community Health

SCHOOL-BASED HEALTH CENTER PARENTAL CONSENT FORM

3200 Senter Rd, San Jose, CA 95111 **Please email the completed form to the secure mailbox at: bh.sbhc@bach.health**

Please know that your child can use the School-Based Health Center and see your other doctors.
Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

STUDENT INFORMATION

Student Last Name: ___________________________________

Student First Name: ___________________________________

Date of Birth: __________/__________/___________
Month Day Year

Student Address:____________________________________
____
City State Zip Code

Student email:________________________________

***Student Social Security Number:** ____________________

Sex: ☐ Male ☐ Female Grade _____________

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian
☐ Asian/Pacific Islander ☐ Other _____________

List the student's regular doctor, if they have one?

Name: ____

Telephone: ____

Address: ____

Indicate the Pharmacy where we can send prescriptions.

Pharmacy____

Pharmacy Address: _____________________________________

Pharmacy Tel: ____

***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

Parent/ Legal Guardian:

Last Name: __________________ First Name: _______________

Home/Work Tel: ____

Cell Phone: ____

Email: ____

Date of Birth: __________/__________/___________
Month Day Year

Parent/Legal Guardian:

Last Name: __________________ First Name: ______________

Home/ Work Tel:____

Cell Phone:____

Email :____

If legal guardian , relationship to the student:

☐Grandparent ☐ Aunt/Uncle ☐Foster Parent ☐ Other: _________

Home /Work Tel: ____

Cell: ____

Email: ____

Preferred Language of Parent/ Guardian:___________________

ADDITIONAL EMERGENCY CONTACT

Name: ____

Relationship to Student: _________________________________

Home or Work Tel:______________________________________

Cell: ____

INSURANCE INFORMATION

Does your child have Medi-Cal?

☐ No ☐ Yes: ID # __________________________

Does your child have other health insurance?

☐ No ☐ Yes, Health Plan: ____________________________

Member ID/Policy Number: ______________________________

Health Insurance Phone: _________________________________

If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?

☐ No ☐ Yes What is the best time to contact you? _________

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the health professionals of BAY AREA COMMUNITY HEALTH Andrew Hill High School as part of the school-based health center program. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses and dilation of the eyes), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the Andrew Hill High School School-Based Health Center as long as my child is a student at the school. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child. By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents, married or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

X ____ ________________

Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I,____, have read and understand the release of health information in Box 2 on this form, and give my permission for the Bay Area Community Health School-Based Health Center to share the information listed in Box 2 of this document to Santa Clara County Public Schools and East Side Union High School District and Andrew Hill High School, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety. My signature indicates my consent to release medical information as specified in the Box 2 section only. This information may be protected from disclosure by federal privacy law and California law. This authorization to share my child's health information is valid from ______________________ to __________________________.

I give the Bay Area Community Health School-Based Health Center permission to:

[Check the appropriate box(es)]

□ Disclose my child's complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

□ Disclose my child's complete health record except for the following information:

□ Mental health records
□ Communicable diseases including, but not limited to, HIV and AIDS
□ Alcohol/drug abuse treatment records
□ Genetic information
□ Other (Specify) ____

X ____ ________________

Date

I understand that I am permitted to revoke this authorization to share my child's health data at any time, and can do so by submitting a request in writing to Bay Area Community Health.

The revocation will not prevent my child from receiving any treatment or benefits they are entitled to receive, provided this information is not required to determine if they are eligible to receive those treatments or benefits or to pay for the services they receive.