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. The SBHC is staffed by licensed professionals consisting of medical and mental health.

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 most of the services listed below at no cost to you, regardless of insurance status. The SBHC will bill insurance, and there is a sliding scale for any services not covered by insurance.

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 the services of our School-Based Health Center, 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 return this form to the campus clinic or email completed form to the secure mailbox at: sbhc.bh@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:

If legal guardian , relationship to the student:

☐ Grandparent ☐ Aunt/Uncle ☐ Foster Parent

☐ Other: _____

Last Name: _____ First Name: _____

Home/Work Tel: _____

Cell Phone: _____

Email: _____

Preferred Language of Parent/ Guardian:_____

Parent/Legal Guardian:

If legal guardian , relationship to the student:

☐ Grandparent ☐ Aunt/Uncle ☐ Foster Parent

☐ Other: _____

Last Name: _____ First Name: _____

Home/ Work Tel:_____

Cell Phone:_____

Email :_____

Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____

Relationship to Student: _____

Home or Work Tel:_____

Cell: _____

Preferred Language of Emergency Contact:_____

BAY AREA COMMUNITY HEALTH

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

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. 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. I am further authorizing the School-Based Health Center to release specific medical information to East Side Union High School District, Santa Clara County Public Schools, and the California Department of Public Health either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.

X _____ _____

Date

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed 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.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. Annual health questionnaire/survey.