School Based Health Centers
of Jefferson Parish

Health & Behavioral Health Care

Bonnabel High
2801 Bruin Drive
Kenner, La. 70065
Phone: 504-303-6676
Fax: 504-303-6680

Butler Elementary
Worley Middle
Isaac Joseph Elementary
St. Pierre Academy
300 4th Street
Westwego, La. 70094
Phone: 504-341-0645
Fax: 504-341-0689

John Ehret High
4300 Patriot Street
Marrero, La. 70072
Phone: 504-371-1318
Fax: 504-371-1328

Riverdale High
Jefferson Elementary
240 Riverdale Drive
Jefferson, La. 70123
Phone: 504-834-5026
Fax: 504-834-3854

West Jefferson High
2200 8th Street
Harvey, La. 70058
Phone: 504-367-4407
Fax: 504-367-4327

Behavioral Health Care Only

Chateau Estates School
Douglass Community School
East Jefferson High
Grace King High
Strehle Community School

Dear Parent/ Guardian:

The Health Center will be open again this year for students. Our licensed medical staff will be here to treat your child for any health issue that may arise at school.

The Health Center's staff consists of a registered nurse, a medical doctor, a nurse practitioner, a child and adolescent psychiatrist, and a social worker. The registered nurse, nurse practitioner, and social worker are in the Health Center on weekdays when school is in session. The elementary hours are 8:00 a.m. to 3:00 p.m. The high school's hours are 8:00 a.m. to 3:35 p.m.

The School-Based Health Center will be able to provide medical services such as sports or comprehensive physicals, immunizations, and lab work. The medical staff will be able to assess students who are sick and give over the counter medicines if needed. The social worker is available to provide assessments, education, and counseling as needed. The purpose of the Health Center is to keep students at school and to allow parents to stay at work. Health Centers are in numerous schools around the state and have been providing services successfully to students for over 20 years.

Please fill out the attached consent form carefully if you would like to take advantage of the clinic. A parent or guardian must be the one to print and sign their name on the consent form. Your child cannot be seen in the Health Center without a completed consent form. If the consent form is incomplete, it will be returned for completion.

The consent form will be effective for the entire time that your child is enrolled in a Jefferson Parish Public School System school that is served by the Jefferson Parish School-Based Health Centers. We will send you a one page form every year to update important information.

If you have any questions, please feel free to call the Health Center.

Edna Metcalf

Edna Metcalf, LCSW-BACS
Exec. Director of Health & Social Services,
Jefferson Parish School-Based Health Centers

JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS
LOUISIANA ENROLLMENT/CONSENT FORM

2022-2023

Student's Name: Last First Middle Initial					ID# (Office use only.)
Student's Address (include city):					Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino		
Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race					
Student's Social Security Number:	School:		Student's Grade:		
Preferred Language:	Parent/Guardian Email:		Student's Cell Phone: ( )		
Name of Mother (include maiden name) or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:	
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:	
Emergency Contact:		Relationship:		Phone: ( )	
Emergency Contact:		Relationship:		Phone: ( )	
Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑				Phone: ( )	
Name of Student's Dentist: Please check if student does not have a Dentist ❑				Phone: ( )	
Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:				

Please check the type of Health insurance your child has:

❑ Medicaid/Healthy Louisiana #: _____ (check one below)

❑ Aetna Better Health ❑ Healthy Blue ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑ United HealthCare Community Plan

❑ Medicaid #: _____ ❑ No insurance

❑ Private/Other Insurance Co.

Name:_____

Co. Address:_____

Phone #:_____ Policy #:_____ Group#:_____

Effective Date:_____

Name of policy holder:_____ Relationship to student:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ❒ No ❒ Yes

Please send a copy of insurance card (front and back) to SBHC.

Student's Name:_____ Student's Date of Birth:_____

Does your child have any known allergies to food, medications, insects, etc? Please list.
If your child does not have Health insurance, would you like information on no cost Health insurance? ❑ Yes ❑ No
List of current medications student is on with dosage (how much) and how often:
We understand that the SBHC may participate in one or more Health information exchanges (HIEs), whereby the center may share my health information with other Health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs. We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of School-Based Health Centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.
Confidentiality: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of Health services in general and specifically as they relate to services to minors. All medical and mental Health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant Health information between the Jefferson Parish School Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my Health information is used and shared. I understand that the Jefferson Parish School Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 504-349-8996. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.
Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from: 1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion. 2. Distributing any contraceptive or abortifacient drug device, or similar product. To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

Student's Name:_____ Student's Date of Birth:_____

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available)
(For more information about recommended screenings by age, parents may review the Bright Futures/AAP Periodicity Schedule.)

I, as parent/guardian, understand that I will not be charged for any of the services provided at the School-Based Health Center. I also understand that Jefferson Parish School-Based Health Centers, Access Health Louisiana, or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Jefferson Parish School-Based Health Centers and/or Access Health Louisiana.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the School-Based Health Center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in a Jefferson Parish School-Based Health Center unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

We also understand that the School-Based Health Center is operated by the Jefferson Parish Public School System and its employees and contractors, Access Health Louisiana.

_____ _____
Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Student (optional) Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Student's Name:_____ Student's Date of Birth:_____

MEDICAL HISTORY

PATIENT HISTORY

Please mark any items that apply to your child's medical history

Check if yes	
	ADHD
	Allergies
	Anemia
	Asthma
	Birth Defect
	Bleeding Disorders
	Bone or Joint Problems
	Chicken Pox (if no, vaccine date)

Check if yes	
	Depression
	Diabetes or Pre-Diabetes
	Ear Infection
	Heart Murmur
	High Blood Pressure
	Kidney Problem
	Major Injuries
	Other Mental Health Problem

Check if yes	
	Speech Problems
	Substance Use
	Stomach Problems
	Smoker
	Seizures/Epilepsy
	Special Education
	Thyroid Problems
	Tonsillitis/Strep

FAMILY HISTORY

Please mark any items that apply to your family's medical history an

Check if yes		Which relative?
	Alcoholism/Drug Use	
	Allergies	
	Asthma	
	Bleeding Disorders	
	Cancer	
	Depression-Suicide	
	Diabetes or Pre-Diabetes	

Check if yes		Which relative?
	Genetic Disorder	
	Heart Attack Before Age 55	
	Heart Disease	
	High Blood Pressure	
	Mental Health Problem	
	Seizures	
	Tuberculosis	

SURGERIES & HOSPITALIZATIONS	Check if yes	Year/Hospital	Reason or Type of Surgery
Has your child ever been admitted to a hospital for a medical or mental health condition?			
Has your child ever had surgery?			

BEHAVIORAL HEALTH	Check if yes	If yes, please explain
Does your child take medication for ADHD, depression or other mental health problem?		
Are there any behavioral health issues or concerns at this time?		
Any special needs that we should be aware of?		

Student's Name:_____ Student's Date of Birth:_____

JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS
OVER THE COUNTER MEDICATIONS

The following over the counter medications* have been approved by the physician of the Health Center to be administered to your child by the Registered Nurse if needed:

Acetaminophen (Tylenol)
Ammonia Inhalants
Anti-nausea Liquid (Emetrol)
Acid reliever for stomach (Pepcid or Zantac)
Bacitracin
Bactine Spray
Benadryl (Dipenhydramine)
Benzoin Topical
Betadine Solution
Caladryl Clear
Calamine Lotion
Chloraseptic Spray
Colace
Cough Drops
Debrox (Ear Wax Removal Drops)
Eye Wash Solution
Glucose Gel or Tablets
Guaifenesin or Guaifenesin DM
Hydrocortisone 1% Cream or Ointment
Hydrogen Peroxide
Ibuprofen (Advil)
Isopropyl Alcohol
Immodium
Loratadine (Claritin)
Lotramin AF
Maalox
Medicaine
Mylanta
Nasal Relief Spray
Natural Tears
Neosporin
Oral Pain Relief Gel (Orajel or Anbesol)
Pepto Bismol
Sore Throat Lozenges
Sterile Water
Stik It Skin Adherent
Sudafed PE (Phenylephrine HCl 10 mg Tabs)
Tums
Vaseline
Vitamin A&D Ointment

*Generic form of medication may be substituted.

I agree that this student may receive all of the medications offered at the School-Based Health Center except those which I have written here:

_____

Parent's or guardian's Signature

Student's Name:_____ Student's Date of Birth:_____

Jefferson Parish School-Based Health Centers

NOTICE OF PRIVACY PRACTICES

Effective 4/14/2003

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

If you have any questions, please contact our Privacy Office at the address or phone number at the end of this Notice.

WHO WILL FOLLOW THIS NOTICE?

Jefferson Parish Health Centers provides Health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- Any Health care professional who treats you at any of our locations;
- All departments and units of our organization
- All employed associates, staff or volunteers of our organization,
- Any business associate or partner of Jefferson Parish School-Based Health Centers with whom we share Health information.

OUR PLEDGE TO YOU

We understand that medical and billing information about you is personal. We are committed to protecting the privacy of your medical and billing information. We create a designated record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or Notices regarding the doctor's use and disclosure of your medical and billing information created in the doctor's office. We are required by law to:

- Keep medical and billing information about you private;
- Give you this Notice of our legal duties and privacy practices with respect to your protected Health information;
- Follow the terms of the Notice currently in effect.

CHANGES TO THIS NOTICE

We may change our policies and privacy practices at any time. Changes will apply to your protected Health information we already hold, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our Notice and post the new Notice in waiting area and exam rooms. You can receive a copy of the current Notice at any time. The effective date is listed just below the title.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

- We may use and disclose medical and billing information about you for **treatment** (such as sending medical information about you to a specialist as part of a referral**); to obtain payment for treatment** (such as sending billing information to your insurance company or Medicaid and **to support our Health care operations** (such as comparing patient data to improve treatment methods.)

- We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected Health information about you without prior authorization for **public Health purposes, abuse or neglect reporting, Health oversight audits or inspections, research studies, or during emergencies.** We may also disclose protected Health information **when required by law**, such as in response to request from law enforcement officials in specific circumstances, or in response to valid judicial or administrative orders.

- We may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, Health-related benefits or services that may be of interest to you.**

- We may disclose medical and billing information about you to a **friend or family member who is involved in your medical care** or to disaster relief authorities so that your family can be notified of your location and condition.

Student's Name:_____ Student's Date of Birth:_____

OTHER USES OF MEDICAL INFORMATION

- In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing your protected Health information. If you choose to authorize our use or disclosure or your protected Health information, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- In most cases, **you have the right to look at or obtain a copy of medical and billing information** contained in the designated record set that we use to make decisions about your care. If you request copies, we may charge a fee for the cost of copying, related supplies or postage. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your designated record set is incorrect or if important information is missing, **you have the right to request that we correct the records**. Your request may be submitted in writing. A request for amendment must provide your reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determined that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

- **You have the right to a list of those instances where we have disclosed medical and billing information about you,** other than for treatment, payment, Health care operations or where you specifically authorized a disclosure. When you submit a written request, the request must state the time period desired for the accounting, which must be less than a six (6) year period and starting after April 14, 2003.The first disclosure will be provided to you at no cost; other requests will be charged in accordance with our cost to produce the list. We will inform you of the cost before your incur any charges.

- **You have the right to request that your medical and billing information be communicated to you in confidential manner**, such as sending mail to an address other than your home. You must notify us in writing of the specific way or location for us to communicate with you.

- **You may request in writing, that we not use or disclose protected Health information about you** for treatment, payment or Healthcare operation or to persons involved in your care except when specifically authorized by you, or when required by law, or in an emergency. We will consider your **request but we are not legally required to accept it.** We will inform you of our decision.

- **All written requests or appeals should be submitted to our Privacy Office listed at the end of this Notice.**

COMPLAINTS

- If you are concerned that your privacy right may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy office (listed below).

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office Civil Rights. Our Privacy Office will provide you the address upon request.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

PRIVACY OFFICE CONTACT INFORMATION
Edna Metcalf
Jefferson Parish School-Based Health Centers
822 South Clearview Parkway
Metairie, La. 70003
504-349-8996
504-349-8985 fax

Student's Name:_____ Student's Date of Birth:_____

Jefferson Parish School Based Health Center
Acknowledgement and Understanding of the
"Notice of Privacy Practices"

I hereby give consent/permission to Jefferson Parish School Based Health Centers to use and disclose my child's protected health information for the purposes of treatment, payment, and health care operations.

I have received a copy of the Jefferson Parish School Based Health Center "Notice of Privacy Practices," which provides detailed information about how they may use and disclose my child's protected health information. By agreeing to the terms provided therein, I will consent to my child's protected health information being shared with a Health Information Exchange.

I understand that:

- I have a right to request a restriction of how his/her protected health information is used and/or disclosed, but the request must be in writing,
- Jefferson Parish School Based Health Center is not required to grant my request, but if the Jefferson Parish School Based Health Center does grant the request, it will be binding.

_____ _____
Signature of Parent or Legal Guardian Date

Student's Name:_____ Student's Date of Birth:_____

Jefferson Parish Schools School Based Health Centers
Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a health care or mental health provider to deliver services to an individual when he/she is located at a different site than the provider.

I acknowledge that I have been notified of my right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may revoke my consent to telemedicine/telehealth services orally or in writing. As long as this consent is in force (has not been revoked) Jefferson Parish School Based Health Centers may provide health care or mental health services to me via telemedicine/telehealth without the need for me to sign another consent.

I understand that the laws that protect privacy and the confidentiality of medical/mental health information also apply to telemedicine/telehealth. I understand that as an existing patient of Jefferson Parish School Based Health Centers my health information will be used and disclosed in accordance with Jefferson Parish School Based Health Centers' Notice of Privacy Practices, a copy of which may be requested at any time. I understand that I can obtain copies of my medical or mental health records by contacting my provider's office. The clinic staff will release my records after they have received written authorization permitting the release of my medical or mental health records to my designated recipient.

I understand that in the event of a technology or equipment failure I should call my providers office to receive further instructions. I understand that telemedicine/telehealth is not used to provide emergency care and such emergency care should be sought by calling 911.

By signing below, you are acknowledging the above information and are consenting to receiving telemedicine/telehealth services from Jefferson School Based Health Center and its participating providers.

_____ _____

Signature of Parent/Legal Guardian (unless student is 18 years old or above) Date

Student's Name:_____ Student's Date of Birth:_____

Information About Louisiana Medicaid Insurance

In Louisiana, you qualify to receive Medicaid if you:

- Receive Supplemental Security Income (SSI) from the Social Security Administration (SSA)
- Get financial help from the Office of Family Support (OFS) through the Family Independence Temporary Assistance Program (FITAP)

You may also qualify for Medicaid coverage if you:

- Are disabled according to the Social Security Administration's definition
- Have corrected vision no better than 20/200
- Are a low-income parent of children under age 19
- Are a child under age 19
- Are pregnant
- Have no insurance and need treatment for breast and/or cervical cancer
- Receive Medicare coverage and are low-income

How Do I Apply?

There are several ways you can apply for Medicaid or get more information:

1. Apply now or renew coverage for any Medicaid program by visiting the Louisiana Medicaid Online Application (OLA). https://sspweb.lameds.ldh.la.gov/selfservice/
   Once you submit the online application, it is sent immediately to the Medicaid office for processing, and there is no delay for mailing or faxing a paper form.

2. Call the Medicaid hotline toll free at **1.888.342.6207** for help applying. Agents are accepting calls Monday through Friday from 7 a.m. to 4:30 p.m.

3. Ask your SBHC for an application form and/or assistance. Paper applications can be mailed or faxed.

If your child already has Louisiana Medicaid or another insurance, please provide the SBHC with a copy of the front & back of your insurance card.