

School Based Health Authorization

|  |  |
| --- | --- |
| **Student’s Name: Date of Birth:** | |
| I understand that the Office of Public Health (“OPH”), Adolescent School Health Program provides oversight to SBHC’s 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. I understand that the School Based Health Centers (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. | |
| **Confidentiality:** The 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) and the Family Educational Rights and Privacy Act (FERPA). I consent to the exchange of relevant health information between Health Centers in Schools and the student’s personal medical provider or Our Lady of the Lake Physician Group provider 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 Health Centers in Schools has the right to change this notice at any time. I may obtain a current copy by contacting the Health Centers in School’s main office, at (225) 343-9505. 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 504-5683504.* | |
| **BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW HEALTH CARE CENTERS IN SCHOOLS TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:** | |
| * Primary and preventive health care * Comprehensive history and physical examinations health screenings * Laboratory/diagnostic testing * Case management * Acute care for minor illness/injury (including medications), if indicated | * Management of chronic diseases * Behavioral health services * Referral and follow-up for emergencies * Referral to specialty care * Health education & prevention programs * Dental services (where available) * Telehealth visits with a primary care, specialty, or behavioral health care provider |
| **Please initial below:**  If my child requires COVID-19 testing, I do hereby consent to HCCS or Our Lady of the Lake Physician Group administering COVID-19 testing and notification of results.  I do consent to HCCS staff administering immunizations according to the American Academy of Pediatrics immunization schedule and CDC guidance. | |

|  |
| --- |
| **Student’s Name: Date of Birth:** |
| I understand that there will not be payment required for any of the services provided at the school-based health center. I also understand that **Health Centers in Schools** or the medical provider will bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to **HCS**.  **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 an East Baton Rouge Parish School or Charter School (contracted with Health Care Centers in Schools), 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 **OLOL Children’s Health Centers in Schools** and its employees/contractors and not by the local school board. |
| 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.*  *Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures.* |

Effective Date: December 23, 2020