Attention Parents/Guardians:

Your student's school and Shalom Health Care Center have joined forces to operate a school-based health clinic, providing access to quality health services for students. It is our goal to help your family by providing medical services for your child while they are in school, assisting your child's physician with their healthcare needs, and providing access to healthcare for those who do not have any healthcare services.

Our clinics are staffed with RNs, LPNs, medical assistants, or Advanced Practice Providers (APP) such as Nurse Practitioners or Physician Assistants. An APP has a Master's degree or higher, and has been trained and licensed by the state to diagnose and treat. Our services are not intended to replace your child's primary care provider. Our intent is to expand access to healthcare by working with families and their health providers to offer quality health care in the school setting.

In accordance with Indiana State Law, all families wishing to receive health services from Shalom school-based clinics (SBC) must sign a consent to treat form and complete a brief medical history. This information provides our medical staff with the most up-to-date medical information for your child. Any information given will remain confidential as part of your child's medical record. The consent form will be invalid if any portion of the form is not fully complete.

This consent form is accepted at any school with a Shalom SBC and is valid through **the entire school year.** A written request to withdraw consent for treatment must be completed by the parent or guardian in order to discontinue services. The parent or guardian is responsible for notifying the clinic of any changes to the student's health history, guardianship and/or demographic information.

This program is provided at no cost to you or your family. Shalom will bill and collect from Medicaid and other third party health insurances your child may have. We do require insurance information be provided in order to provide services. This ensures our ability to continue school-based clinic services and care for your child.

Thank you for your cooperation and allowing us to participate in your child's health care needs.

Notice of Privacy Practices Summary

This summary describes how Shalom uses and shares your child's information and how you may acquire copies of this information. The full Notice of Privacy Practices is available at www.shalomhealthcenter.org as well as each of our clinics.
We may use or share your child's information for the following:

- Treatment-such as discussions of your child's care amongst the medical staff.
- Payment-such as billing insurance for services provided to your child.
- Operations-such as working to improve our quality of care, advertising services provided, etc.
- Other ways- such as mandatory disease reporting to county and state health officials, responding to court requests, appointment reminders, test result letters, etc.

Exceptions- Different laws may apply to mental health, family planning, drug and alcohol and AIDS/HIV treatment.
Any other reasons for use or sharing of your child's health information will be completed only with your specific written permission or as required by law.

Regarding your child's information, you have the following rights:

- Requesting restrictions on how your child's information is shared. Shalom is not required to agree to requested restrictions, but will notify you if we cannot accommodate your request.
- Acquire and inspect a copy of your child's health record.
- Ask that incorrect or incomplete information in your child's medical record be corrected.
- Ask that we contact you by mail or phone to an alternate address and/or phone number.
- Change your mind if you previously granted sharing/use of your child's information for reasons other than those listed above.
- Receive a list of the times we shared your child's information. This list will only contain the times that the law requires us to record.

Changes:
As we serve our patients, we may change how we handle your child's information. If we make any changes, we will give you a new notice the next time you visit our clinic. You may call or write at any time to check if we have made any changes.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with Shalom's Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services. Your care will not be affected in any way if you choose to file a complaint.

Please address questions or complaints to:
Shalom Privacy Officer
3400 Lafayette Road, Suite 200
Indianapolis, IN 46222
(317) 291-7422

Shalom
HEALTH CARE CENTER

Informed Consent for School-Based Health Clinic Services as provided by Shalom Health Care Center Inc. for School Year 2022-23

I give permission for **(Student's Full Name)** _____ **(Date of Birth)** _____ to receive health services from the school-based clinic (SBC) at my child's school. I understand that the school-based clinic provider does not replace my child's Primary Care Provider and cannot take care of all my child's health care needs.

I. I have read the information provided regarding the school-based health clinic and the release of information and I understand what services the clinic will and will not provide. My consent will allow my child to receive health services while he/she is a student at any school with a Shalom SBC. I understand that if I chose to cancel these services, I must provide the request in writing. It will be my responsibility to notify the clinic staff regarding changes in guardianship, contact information, and health history.

II. Information Privacy: I have been informed that Shalom has prepared a detailed NOTICE OF PRIVACY PRACTICES regarding my child's personal health information. I understand that the terms of the notice may change, and current notices will be available on Shalom's website and facilities.

III. Release of Information: I understand the services provided by the school-based health care clinic are confidential. The clinic will use and disclose my child's personal health information to provide treatment and or improvement of healthcare operations. My child's information may be shared with my child's physician/provider, appropriate school staff, or with my child's insurance provider for legitimate purposes. I authorize the release of my child's medical information to other providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation. In addition, I give my consent to the clinic staff to look at, and update my child's school health record, including immunizations.

_____ **(Parent initials) I acknowledge I have received a copy of Shalom Health Care Center, Inc Notice of Privacy Practices.**

Signature of Parent/Guardian: _____ **Date:** _____

Printed name of Parent/Guardian: _____ **Relationship:** _____

SERVICES WILL NOT BE PROVIDED WITHOUT A SIGNED PARENTAL/GUARDIAN CONSENT AS REQUIRED BY THE INDIANA STATE LAW.

INSURANCE INFORMATION (*REQUIRED SECTION*)**
Insurance is not required to be seen in a Shalom clinic, however, this section MUST be completed!
□ Medicaid Type: _____ Member ID: _____
□ Private Insurance: _____ Member ID: _____
Group Number: _____ Name of Policy Holder: _____ Relationship to patient: _____
□ No Insurance: □ Please refer my family to a free insurance navigator to help with all options available.
*As a Federally Qualified Health Center, Shalom is required to attempt to collect yearly household size and income information in order to continue receiving special funding for our school-based clinics. Please support our programs by providing the following information: Number of people living in home: _____ Total household income: _____ □ Choose not to disclose

PATIENT INFORMATION

Legal Last Name:	**Legal First Name**	**Preferred or Nickname**	**DOB (mm/dd/yy):**
Street Address (with Apt #, if applicable):		**City:**	**Zip Code:**
Parent/Guardian email:		**Daytime contact#:** ( )	**Best way to contact urgently:** Call Text Email
Gender: □ female □ male □ other:_____	**Race:** □ Asian □ Native American □ Black □ White □ Other: _____ □ Choose not to disclose	**Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Choose not to disclose	**Preferred Language:** □ English □ Spanish □ Other: _____ □ Interpreter needed
Siblings at the school**:**		**School:**	

DAYTIME & EMERGENCY CONTACTS

Parent/Guardian Name:_____ Relationship to student: _____ Phone: _____

Parent/Guardian Name:_____ Relationship to student: _____ Phone: _____

Parent/Guardian Name:_____ Relationship to student: _____ Phone: _____

EMERGENCY contact if Parent/Guardian cannot be reached:

Name:_____ Relationship to student: _____ Phone: _____

HEALTH INFORMATION- Please answer ALL questions

Does your child have or has had…	NO	YES	If yes, please give all details in the section below
Any allergies to: ● **Medicine** ● **Food** ● **Insects**			What kind? ● What reaction they have ● treatment
Any medications they take daily or sometimes, including over the counter meds such as vitamins or allergy medicine?			Medication name/dose ● How often it is taken ● Taken for what? 1, _____ 2. _____ 3. _____
Surgery in the past			What surgery ● when ● for what reason?
Environmental or Seasonal allergies			
Vision problems, including glasses			
Hearing problems, including hearing aid			
Headaches/ history of head injury			
Seizures			
Skin problems (ex: eczema)			
Heart disease/murmurs/ high blood pressure			
Lung problems, including asthma			
Diabetes			
Sickle Cell Disease			
Stomach problems, including constipation			
Kidney or bladder problems			
Mental health concerns (ex: depression, ADHD, autism)			
Learning difficulties			
Other:			

For office use only: ☐ ACCT# _____ ☐ web enabled ☐ added to roster ☐ consent status in database ☐ scanned into ECW