Dear Parent/Legal Guardian,

The high school your student is enrolled in provides expanded medical services, such as care for acute illnesses, primary prevention and emergency health care, and treatment for chronic conditions. The goal of the program is to improve the overall health status of students through shared school-based and community resources helping to assure that students are healthy in the classroom and ready to learn.

The School-Based Health Clinics Program is a partnership between the Florida Department of Health in Pinellas County, Juvenile Welfare Board (JWB), Pinellas County School System, Suncoast Center, Inc., and the administrations at Boca Ciega, Gibbs, Northeast, Largo and Pinellas Park High School.

The expanded services are funded by JWB through local taxes. As part of the funding, the Florida Department of Health in Pinellas County is required to collect personally identifiable information on students for program accountability and quality improvement activities.

This packet of material contains information on the program as well as forms for enrolling your student in the clinic.

If you would like your student to receive additional health services AT NO COST, please complete and sign the following forms and return them to the school clinic as soon as possible:

Consent for School-Board Clinic Services – complete the entire form and sign Section 3 and, if your student has Medicaid, check the box in Section 4 and sign the bottom.

Adolescent Health History – complete the entire form.

Initiation of Services – complete and sign Part VII.

Interagency Consent for Services and Release of Information – complete and sign.

Notice of Privacy Practices – keep for your records.

If you have any questions about these forms or services, please contact the clinic at your child’s school:

Boca Ciega High School Clinic: (727) 893-2780 ext. 2026
Gibbs High School Clinic: (727) 893-5452 ext. 2026
Largo High School Clinic: (727) 588-3758 ext. 2026
Northeast High School Clinic: (727) 570-3138 ext. 2325
Pinellas Park High School Clinic: (727) 538-7410 ext. 2026

Florida Department of Health in Pinellas County
205 Dr. Martin Luther King Jr. St. N. St. Petersburg, FL 33701-3109
PHONE: (727) 824-8600 FAX (727) 820-4265
FloridaHealth.gov
1. Student information (please print clearly)

Last Name: __________________ Date of Birth: ________________
First Name: _______________ School: ____________________
Middle Name: ______________ Grade Attending: ____________
Social Security #: __________________

2. Services Available to High School Students at NO Cost:

Please check any services we cannot provide to your child.

☐ School/Sports Physicals ☐ Care For Minor Illness & Injuries
☐ Immunizations ☐ Administer Over the Counter Medications (e.g. Tylenol, Ibuprofen, Tums)
☐ Lab Tests (e.g. throat, urine cultures) ☐ Social, Emotional, and Mental Health Counseling

Comments:

3. Agreement for Student Services

Please read carefully and sign:

I do hereby give my consent for the above named student to receive services at the Florida Department of Health School-Based Clinic. All services listed above that have not been checked will be available to my child. I further understand that all services authorized by myself will be available at no cost.

Please check one: ☐ Parent ☐ Legal Guardian ☐ Student (if 18 or older)

Print Name: __________________ Signature: ___________ Date: ___________

The Following Questions are for Data Gathering Purposes Only

1. Is your child covered by Private Insurance? ☐ Yes ☐ No
2. Is your child covered by Healthy Kids? ☐ Yes ☐ No
3. I am aware of Florida Kid Care program and I know how to apply for it. ☐ Yes ☐ No*

*If you answered no to question #3, please contact the clinic in your school or call 1-888-540-5437 for information and for help applying.

4. Medicaid Coverage Consent

Is your child covered by Medicaid? ☐ Yes ☐ No  (If Yes, please continue. If No, please skip the rest of Section 4 below.)

State of Florida Consent for Billing Medicaid

Although all school-based clinic services are available at no cost to you, the Florida Department of Health does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

I hereby assign the Florida Department of Health all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health. I further authorize the Florida Department of Health at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Please check one: ☐ Parent ☐ Legal Guardian ☐ Student (if 18 or older)

Print Name: __________________ Signature: ___________ Date: ___________

5/2019
Adolescent Health History
Confidential

Name: ___________ ___________ ___________
Last First Middle
Date of Birth: __/__/____ Sex: □ Male □ Female
Ethnicity: □ Hispanic, if yes where ___________
□ Non-Hispanic ___________
Primary language spoken: ___________
Number of Minor Children: _______
Number of Adults: _______
Household income (before taxes): _______

Medical History

Does your Child have Established Primary Care? Y N
Does your child have allergies?

Name of Personal/ Family Physician:
Allergic Reaction(s):

Date of last visit with Physician:

Last Physical:

Does your child carry epi pen or inhaler? Y N

Does your child have a Dentist? Y N
Is your child taking any Medication? Y N

Date of last dental exam:
Please list:

Please indicate yes responses below and include any additional information:

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<thead>
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<th>Yes</th>
<th>No</th>
<th>Age</th>
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<th>No</th>
<th>Age</th>
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<th>Yes</th>
<th>No</th>
<th>Age</th>
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</thead>
<tbody>
<tr>
<td>ADHD</td>
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<td>Mononucleosis</td>
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<td>Anemia or bleeding disorders</td>
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<td>Nosebleeds</td>
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<td>Asthma</td>
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<td>Pneumonia</td>
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<td>Autism spectrum</td>
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<td></td>
<td>Prediabetes</td>
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<td>Dental problems/cavities</td>
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<td>Premature birth</td>
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<td>Diabetes Type 1 or 2</td>
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<td>Scoliosis/orthopedic problems</td>
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<td>Eating disorder or concerns</td>
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<td>Seizures</td>
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<td>Fainting spells</td>
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<td>Severe acne/skin problem</td>
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<td>Headaches</td>
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<td>Severe menstrual cramps</td>
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<td>High blood pressure or heart disease</td>
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<td>Sickle cell disease</td>
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<td>High cholesterol</td>
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<td>Single kidney</td>
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<td>Hospitalizations</td>
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<td>School academic or social concerns</td>
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<td>Kidney or bladder problems</td>
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<td>Snoring or sleep problem</td>
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<td>Menstrual irregularities</td>
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<td>Stomach problems</td>
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<td>Migraines/headaches</td>
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<td>Testes</td>
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If yes, please describe:

Relationship

Does anyone smoke in the house? Y N

If either biological parent is deceased if yes, cause:

Other:

Other:

Other:
INITIATION OF SERVICES

PART I. CLIENT – PROVIDER RELATIONSHIP CONSENT

Client Name:

Name of Agency: Florida Department of Health - Pinellas County

Agency Address: 205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representative to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory test and/or minor procedures. I may discontinue this relationship at any time.

PART II. DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and healthcare operations.

PART III. COMMUNICATIONS

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my healthcare. In order to receive electronic communications about my health care. I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my user name and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.

___Initial here to authorize and give my express consent to the DOH to make your health care information available to you through the portal.

Email Address: ________________________ I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

___Initial here to remove your email address from the DOH system and stop receiving information through the portal.

PART IV. MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician’s services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V. ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As client/Representative signed below. I assigned to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI. COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER (This notice is provided pursuant to section 119.071(5) (a). Florida Statutes.)

For health care programs the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071 (5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature: ____________________________

Self or Representative’s Relationship to Client: ____________________________

Date: ____________________________

Witness (optional)

Date: ____________________________

PART VIII. WITHDRAWAL OF CONSENT

I ____________________________ WITHDRAW THIS CONSENT. Effective ____________________________

Client/Representative Signature: ____________________________

Date: ____________________________

Witness (optional)

Date: ____________________________

Client Name: ____________________________

ID#: ____________________________

DOB: ____________________________

Original to file; Copy to client

DH8001-IT-01/2017
INTERAGENCY CONSENT
FOR SERVICES AND RELEASE OF INFORMATION

Student Name: ___________________________  Date of Birth: ___________________________

Address: ___________________________  Apartment/Unit: _______  City: ___________  Zip: ________

Telephone Number: ___________________________

School: □ Boca Ciega, Northeast, Gibbs, Pinellas Park, Largo HS  □ Other School: ___________________________

Check the appropriate box then read and sign the Consent Section:

□ As the parent/legal guardian of the above-named student, I, ___________________________, consent to the student receiving services from the Department of Health in Pinellas County and Suncoast Center, Inc.

□ I, the above-named student, consent and agree to receive services from the Florida Department of Health and Suncoast Center, Inc.

The expanded services at the school are funded by the Juvenile Welfare Board (JWB) through local taxes. As part of the funding, the Department of Health in Pinellas and Suncoast Center, Inc. are required to collect additional personally identifiable information on the student for program accountability and quality improvement activities. However, the student will not be denied the basic school health services if you choose not to sign the form. Once the information is received by JWB it is encrypted and de-identified to protect parental and student privacy rights (See JWB Written Statement of Purpose(s) for Collection of Confidential Information form).

Consent Section

I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements.

I authorize the Florida Department of Health in Pinellas County and Suncoast Center, Inc. to release to and receive from the School Board of Pinellas County medical/education records (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

I authorize the Florida Department of Health in Pinellas County, Suncoast Center, Inc., and School Board of Pinellas County to release personally identifiable student information, such as student social security number, name, address, date of birth, household number, household living arrangement (parents, single parent, grandparent etc.), and free and reduced lunch information to JWB.

I also authorize the Florida Department of Health in Pinellas County, Suncoast Center, Inc., and School Board of Pinellas County to release protected health information and all information pertaining to treatment received at the school clinic, home or anywhere else where I am receiving treatment from these providers and any and all other medical information in their control to JWB. I further authorize the Florida Department of Health in Pinellas County, Suncoast Center, Inc., and School Board of Pinellas County to release records may which contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention to JWB.

I understand that the Records will be released and received for the purpose of treatment, payment/reimbursement, quality improvement and research activities.

I understand this consent is in place while the above named student is enrolled in one of the above named Pinellas County Schools. This consent will terminate when the above named student is no longer enrolled in or graduates from one of the above named Pinellas County Schools, except for the purpose of research and compliance reviews. I understand I have the right to revoke this consent at any time. If I revoke this consent, it must be in writing and be presented to the health clinic at the above named school. I understand that if I revoke my consent that it will not apply to any information already released and/or used as a result of my prior consent.

I release the School Board of Pinellas County, Florida Department of Health in Pinellas County, Suncoast Center, Inc., and the Juvenile Welfare Board of Pinellas County, their officers, agents, and employees, from liability for the release of information in accordance with this consent.

Signature of parent/guardian or adult student (over 18 years old) ___________________________  Date ________  Relationship to Student ___________________________

Signature of Witness ___________________________  Date ________
NOTICE OF PRIVACY PRACTICES

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. **Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.**

Your information may be used by certain department personnel to improve the department’s health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department’s divisions, bureaus, and offices.
- Investigations and audits by the state’s Inspector General and Auditor General, and the legislature’s Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;
You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department’s legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.