



## School Based Health Center Fact Sheet

### What is a School Based Health Center?

**School-Based Health Centers (SBHC)** are comprehensive on-site health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents at schools.

**Warrior Wellness Center located within Central High School offers medical, dental and behavioral health services for students and faculty through a collaboration with MarillacHealth. Services will be available throughout the school year.**

### Description of Services Offered:

**Hours & Coverage:** The SBHC is open Monday through Friday 7:30am to 4:30pm during the school year. Although appointments are preferred, students may be seen on a walk-in basis, depending on the problem and availability of the staff. If necessary, appointments are available before or after school. If a student does not have a primary care provider he/she will have phone access to health care providers during the evening, weekends and vacations by dialing the SBHC phone number. A recorded message will direct the caller to the provider on call.

**Why choose a SBHC:** SBHCs offer convenient care that limits the amount of time students are out of class and parents/guardians have to be off work. In many cases, students are able to get same or next day appointments.

**Staffing:** Staff at the SBHC are highly qualified and experienced in providing health care to young people. The Physician Assistant works in collaboration with a physician and is qualified to diagnose, treat illness and prescribe medications. The SBHC staff work with, but do not replace your family doctor or school nurse. Licensed Mental

Health Therapists and Registered Dental Hygienists provide mental/behavioral and oral health services as well.

**Billing & Costs:** No patient will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided, and when available, insurance or Medicaid will be billed. Patients/parents *are* responsible for insurance co-pays and unmet deductible amounts. Students eligible for the free/reduced lunch program may qualify for CHP or Medicaid. Families with private insurance may also qualify for some programs to assist with the cost of care. Information about various programs and how to apply is available from the health center staff. The SBHC depends upon the ability to collect payment from your insurance carrier in order to maintain the current hours of the SBHC.

**Confidentiality:** Confidentiality between the student, parents and the health center is assured. The staff will encourage every student to involve his/her parent/guardian in health care decisions. Since one purpose of healthcare is to reduce high-risk behaviors of some youth, it is important for the students to feel they can have a confidential relationship with their health care provider. By Colorado law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. This also assures development of trust between students and the health center.

|                                     |
|-------------------------------------|
| <b>Consent Signature Checklist:</b> |
|-------------------------------------|

- ☐ MarillacHealth School-Based Health Center General Parent/Guardian Enrollment and Consent for Treatment
- ☐ Parent/Guardian Questionnaire Child/Teen/Family History
- ☐ MarillacHealth School-Based Health Center Immunization Consent Form
- ☐ Notice of Privacy Practices
- ☐ Outpatient General Consent for Treatment and Terms Relating to Payment ("Consent

## ENROLLMENT AND CONSENT FORM

Warrior Wellness Center 550 Warrior Way, Grand Junction, CO 81504

P: 970-200-1603 F: 970-200-1617

### STUDENT INFORMATION \*

Student Name: \_\_\_\_\_ Student SS #: \_\_\_\_\_

Address: \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth date: \_\_\_\_\_

Gender: ☐Female ☐Male ☐Transgender Male ☐Transgender Female ☐Other ☐Choose not to disclose

Sexual Orientation: ☐Straight ☐Lesbian/Gay ☐Bisexual ☐Something Else ☐Don't Know ☐Choose not to disclose

Race: ☐White ☐Black ☐Hispanic or ☐American Indian ☐Native Hawaiian ☐Pacific Islander ☐Other-  
if so list: \_\_\_\_\_

Public Housing ☐No ☐Yes: \_\_\_\_\_ Household Status: ☐Not Homeless

☐ Homeless

### PARENT / GUARDIAN INFORMATION

Father: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ Email \_\_\_\_\_

Mother: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ E-mail \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ E-mail \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ E-mail \_\_\_\_\_

### CONSENT FOR MarillacHealth-Warrior Wellness Center SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at MarillacHealth-Warrior Wellness Center. I understand that this consent form will be good for one year or until I provide the Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving the SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

#### Health Information

1. Doctor's name / phone number: \_\_\_\_\_
2. When was your child's last dental exam? \_\_\_\_\_ Name of Dentist: \_\_\_\_\_
3. If we need to call in a prescription, which pharmacy would you like us to call? \_\_\_\_\_
4. Immunizations:

☐ I give my permission for you to obtain my child's immunization record

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Child's Insurance Information – Please check all that apply and send a copy of the front and back of your insurance card(s)**

☐ **Primary Health Insurance:**

Name of Insured Parent / Guardian \_\_\_\_\_

Birth date of Card Holder \_\_\_\_\_ SSN of Card Holder \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone / Fax Number \_\_\_\_\_

Group & ID Number \_\_\_\_\_

☐ **Secondary Health Insurance:**

Name of Insured Parent / Guardian \_\_\_\_\_

Birth date of Card Holder \_\_\_\_\_ SSN of Card Holder \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone / Fax Number \_\_\_\_\_

Group & ID Number \_\_\_\_\_

☐ **Medicaid: HealthFirst CO CHP+ CACP (please circle one)**

Medicaid ID#: \_\_\_\_\_ Member ID# \_\_\_\_\_

PCP/HMO Provider: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_

☐ **CHP: Name on Card: \_\_\_\_\_ Birth date of card holder: \_\_\_\_\_**

ID or PIN # on card: \_\_\_\_\_ Group #: \_\_\_\_\_

☐ **No health insurance / Request application for sliding fee / CHP / Medicaid**

# NOTICE OF PRIVACY PRACTICES

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

**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.**

If you have any questions, contact Privacy Officer at 970-298-1782; or by mail at 2333 N. 6<sup>th</sup> Street, Grand Junction, CO 81501. To learn more about MarillacHealth, please visit our website at [www.marillachealth.org](http://www.marillachealth.org)

Medical information about you and your health is private. We strive to protect your health records when you are being seen in the clinics. We will use your records to care for you, to bill for care, and to comply with the law.

This Privacy Notice applies to all MarillacHealth clinic services sites. This Notice tells you about the ways MarillacHealth may use or give out information from your private health records. It also explains your rights and responsibilities.

*Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.*

### **Who Follows The Terms of This Notice:**

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical information to do their jobs

### **Acknowledgment of Receipt:**

I understand that, as allowed and required by law, MarillacHealth staff will use and give out my health records, without my consent or authorization, for:

- **Treatment:** Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- **Payment:** MarillacHealth will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- **Healthcare Operations:** MarillacHealth will use my health records to run the clinics and to make sure patients receive quality care.

Please note that there is an attached copy of HIPAA to this consent form, for the parent/guardian of the student receiving medical or mental health counseling services at MarillacHealth-Warrior Wellness Center. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the student receiving services.

I certify that a copy of the Health Insurance Portability and Accountability Act of 1996 was provided with MarillacHealth's consent form, to the parent/guardian of \_\_\_\_\_ / Date of Birth \_\_\_\_\_ on this date.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of MarillacHealth Staff

\_\_\_\_\_  
Date

## Minor Consent to Medical Treatment at MarillacHealth-Warrior Wellness Center at Central High School

The MarillacHealth-Warrior Wellness Center at Central High School provides medical and mental health services to students. Under Colorado law, youth may be able to consent to receive certain health care services on their own, often called “minor consent” services. Some examples of “minor consent” services include mental health counseling, treatment for addiction, reproductive health information, diagnosis and treatment of sexually transmitted diseases, and contraception. We provide or can refer you for these services. If you would like more information about whether you qualify for this care and the services we provide, please just ask us. If you are interested in consenting for your own care, please complete the information below:

**Student Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

1. I am able to consent to my own care because:

\_\_\_\_\_ I am married or have been married

\_\_\_\_\_ I am 15 years old or older, living separate and apart from my parents and managing my own financial affairs

\_\_\_\_\_ I am seeking “minor consent” services. I will tell my health care provider what services I am seeking



2. I understand my consent covers only those services identified. I understand that I can change my mind at a later date and decide I do not want medical or mental health services at the Warrior Wellness Center at Central High School. I also understand that I can ask for new or additional minor consent services at any time.
3. I understand that the MarillacHealth-Warrior Wellness Center at Central High School is required to keep my health information protected but that in some cases, they may need or be required to share it by law. I understand that I can ask for more information about confidentiality and when my information may be shared.

**Signature of Student:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of MarillacHealth Staff:** \_\_\_\_\_

Date: \_\_\_\_\_

**Request to Release or Secure Confidential Information**

**Mesa County Valley School District 51**  
**Hawthorne Building**  
**410 Hill Avenue**  
**Grand Junction, CO 81501**

\_\_\_\_\_

Student ID \_\_\_\_\_

Legal Name of Student

This permission shall be valid for the following duration:

Beginning Date: \_\_\_\_\_, Termination Date: \_\_\_\_\_.

| Records to be Released or Secured |                       |                      |                       |
|-----------------------------------|-----------------------|----------------------|-----------------------|
| Audiometric                       | <input type="radio"/> | Medical (Health)     | <input type="radio"/> |
| Physical Therapy                  | <input type="radio"/> | Occupational Therapy | <input type="radio"/> |
| Speech/Language                   | <input type="radio"/> | Psychiatric          | <input type="radio"/> |
|                                   |                       | Psychological        | <input type="radio"/> |
|                                   |                       | Other (Specify)      |                       |

| Name and Address for First Party | Name and Address for Second Party |
|----------------------------------|-----------------------------------|
| WARRIOR WELLNESS CLINIC          | CENTRAL HIGH SCHOOL               |
| Mouillac Clinic                  | 550 WARRIOR WAY                   |
| 550 WARRIOR WAY                  | GRAND JUNCTION CO 81503           |
| GRAND JUNCTION CO 81503          |                                   |

All information released or secured will be in compliance with the Family Educational Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent (legal guardian), except as provided by law.

Send all information to the following address only:

|  |
|--|
| Mesa County Valley School District #51 Nursing |
| 410 Hill Avenue                                |
| Grand Junction, Colorado 81501                 |
| Attn: _____                                    |

**Parental Consent:**

Consent for two-way verbal communication: ☐

Consent for two-way written communication: ☐

I understand that consent is voluntary and may be revoked at any time in writing.

I hereby authorize the transfer of information as indicated above: Yes ☐ No ☐

Signature of Parent (Legal Guardian) \_\_\_\_\_

Date \_\_\_\_\_