Indian Head Elementary School Based Health Center
Consent for Health Services and Treatment

Student Name:_____

Student Address:_____

Student Date of Birth:_____

Name of Parent or Guardian:_____

Please review the following information before signing the consent form.

I give permission for my child _____, to enroll in the School Based Health Center program. I consent to his/her receiving services which may include complete physical examinations, immunizations, treatment for chronic and acute health problems, health screenings, limited laboratory, and diagnostic tests (including COVID-19, flu, and strep), administration/prescribing of medications, health education, case management, and/or referrals for any services not provided at the school based health center to include mental health, and social services. I give permission for School Based Health Center (SBHC) professionals and school Health Services staff to share information or records as needed to provide appropriate services to my child through the SBHC and support my child's success in school.

- The parent/guardian may or may not be present at the time services are provided but will be notified by phone, text, or by secure messaging through the student's portal of the Electronic Health Record when a child receives services in the SBHC. **I understand that at this time Maryland law does not require parental consent or notification for the following services: treatment or advice about substance use, alcoholism, sexually transmitted infections, pregnancy or contraception to minors under 18 years of age, and mental health services to minors aged 16 years or older.**

● All SBHC records are confidential and only the SBHC staff and providers will have access to a child's SBHC records and information, unless the parent/ guardian gives written consent, or the minor patient gives written consent, in the event the minor is receiving treatment for which the minor has the authority to consent.

● Services at the SBHC will be provided by staff employed or contracted with Charles County Department of Health.

● Information about your child may be shared with the child's medical provider and school medical staff if deemed necessary by the SBHC provider.

● If your child has health insurance through an insurance company that participates with Charles County Department of Health, the insurance company will be billed for services provided in the SBHC and the insurance company may be provided required information about the child's health status or other information necessary to process claims.

● If your child has health insurance through an insurance company that does not participate with Charles County Department of Health or is uninsured, you will be billed for services given in the SBHC based on a sliding scale.

● If your child does not have health insurance, please indicate this on your enrollment form and we can connect you with Charles County Department of Health staff to assist in identifying options for coverage.

● I authorize the payment of medical benefits to Charles Department of Health for services rendered in the SBHC.

● All enrolled children will be treated regardless of the family's ability to pay or insurance status.

☐YES: I understand the description of services and policies of the SBHC as stated above and give permission for my child to enroll and receive services in the SBHC. Authorization is only valid for the school year during which this consent was signed and will need to be renewed each school year. This includes consent for my child to be signed out of school, escorted to the School Based Health

Center and back to school by SBHC staff. I further agree that I will promptly inform the SBHC in writing of any changes in my child's physical health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child. I understand I may revoke my consent for participation in the School Based Health Center Program at any time by submitting the request in writing. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation.

☐ NO: I do not give permission for my child to receive SBHC services.

X _____

Signature of Parent/Guardian

Name of Parent or Guardian:

Date:

Indian Head Elementary School Based Health Center Enrollment Form

Select School Student Attends:

My child attends:_____
My child's grade is: _____

My child's homeroom teacher is: _____

Student's Last Name: _____
Student's First Name: _____
Date of Birth: _____/ _____/ _____
Month Day Year

Student's Social Security Number:_____ - _____ - _____

Gender: ☐ **Male** ☐**Female** ☐**Prefer not to respond**
Ethnicity: ☐ **Hispanic** ☐ **Black** ☐ **White** ☐ **American Indian** ☐ **Asian Pacific Islander**
☐**Other**

Student Address: _____

_____

Student's Primary Care Doctor
Name of Doctor: _____
Doctor's Office Phone Number: _____

Pharmacy
Name of Pharmacy: _____
Pharmacy's Phone Number: _____

Parent/Guardian Information
Mother: First Name: _____ Last Name: _____
Father: First Name: _____ Last Name: _____
Legal Guardian, if applicable
First Name: _____ Last Name: _____
Relationship of legal guardian to student
☐ Grandparent ☐Aunt or Uncle ☐ Other**:** _____
Contact Information for parent or guardian
Cell**:** _____
Home Tel**:** _____
Work Tel**:** _____

Additional Emergency Contact
Name**:** _____
Relationship to Student**:** _____
Cell**:** _____
Home Tel**:** _____
Work Tel**:** _____

INSURANCE INFORMATION

Does your child have Medicaid coverage?
☐ **No** ☐ **Yes: Medicaid ID#: _____**
Which Plan? _____

Does your child have coverage through your employer or any other type of health insurance?

☐ **No** ☐ **Yes: Health Plan: _____**
Member ID/Policy Number: _____
Health Insurance Phone Number: _____
If your child does not have health insurance, would you like to be contacted by someone from the Charles County Department of Health? ☐ **No** ☐ **Yes**

NOTE: If your child does not have health insurance, they are still eligible to receive service. You may apply for the Sliding Fee program later in this form.

SBHC MEDICAL AND FAMILY HISTORY

STUDENT'S HEALTH HISTORY

*Daily Medications:

_____
_____
_____
_____
_____

*List any allergies to Medication/ Food /
Environmental:_____
_____
_____
_____
_____

Has your child had any recent hospitalizations or surgeries?
☐ No ☐ Yes: If yes, please list:

_____
_____
_____

*Health Conditions:

__ NONE
__ ADD/ADHD
__ Allergies
__ Anemia
__ Anxiety
__ Asthma /Trouble Breathing
__ Autism
__ Bipolar Stomach Problems
__ Blood Disorder
__ Cancer
__ Constipation
__ Developmental Disability
__ Diabetes
__ Frequent Ear Infections
__ Headaches/Migraines
__ Hearing /Vision Problems
__ Heart Condition * If YES, is pre-med required by cardiologist?
__ High Blood Pressure
__ HIV/ AIDS
__ Kidney / Bladder Problems
__ Lead Poisoning
__ Liver Problems
__ Mental Health Disorder
__ Obesity
__ Scoliosis
__ Seizures/Epilepsy
__ Sickle Cell Anemia
__ Skin Issue
__ Stomach Problems
__ Stroke
__ Thyroid Problems
__ UTI/Bladder Infection

Health Condition Additional Information:

_____

_____

Surgical History:

_____

_____

Hospitalizations (list year and reason):

_____

_____

FAMILY MEDICAL HISTORY (Parents and siblings only)

Please check all that apply:

__ Child is Adopted and/or Family Medical History is Unknown*

__ NONE

__ Asthma

__ Autism

__ Blood Disorder

__ Cancer

__ Developmental Disability

__ Diabetes

__ Hearing / Vision Problems

__ Heart Condition

__ Mental Health Condition

__ Scoliosis

__ Sickle Cell Anemia

__ Substance Use Disorder

Family Medical History Additional Information: _____

FAMILY SOCIAL HISTORY Please provide the following information:

*Child Lives With:

__ Both Parents

__ Mother

__ Father

__ Relative

__ Other

*Anyone In Home Smoke

__ YES

__ NO

CHARLES COUNTY DEPARTMENT OF HEALTH
AND YOUR HEALTH INFORMATION

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 CAREFULLY.

Introduction

The Charles County Department of Health (CCDOH) is committed to protecting your health information. CCDOH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your health care, CCDOH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. CCDOH and its Business Associates are required to follow the privacy practices described in this Notice, although CCDOH reserves the right to change our privacy
practices and the terms of this Notice at any time. You may request a copy of the new Notice from any CCDOH agency. It is also posted on our website at https://charlescountyhealth.org/notice-of-medical-practices/

Permitted Uses & Disclosures

CCDOH employees will only use your health information when doing their jobs*.* For uses beyond what CCDOH normally does, CCDOH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions*.* The following are some examples of our possible uses and disclosures of your health information:

Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:

- **For treatment:** CCDOH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, CCDOH health care providers may need to review your treatment with your health care provider for medical necessity or for coordination of care.

● **To obtain payment:** CCDOH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.

● **For health care operations:** CCDOH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures of Health Information Required or Permitted by Law:

● **Information purposes:** Unless you provide us with alternative instructions, CCDOH may send appointment reminders and other materials about the program to your home.

● **Required by law:** CCDOH may disclose health information when a law requires us to do so.

● **Public health activities:** CCDOH may disclose health information when CCDOH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.

● **Health oversight activities:** CCDOH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.

● **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** CCDOH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

● **Research purposes**: In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, CCDOH may disclose health information to assist medical research.

● **Avert threat to the health or safety:** In order to avoid a serious and imminent threat to health or safety, CCDOH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen CCDOH 4617 (07/17) 2 the threat of harm.

● **Abuse and neglect:** CCDOH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. CCDOH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

● **Specific government functions:** CCDOH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

● **Family, friends, or others involved in your care:** CCDOH may share your health information with people as it is directly related to their involvement in your care or

payment of your care. CCDOH may also share your health information with people to notify them about your location, general condition, or death.

- **Worker's compensation:** CCDOH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** CCDOH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a CCDOH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, CCDOH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** CCDOH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** CCDOH may conduct the above-described activities ourselves, or we may use non-CCDOH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** CCDOH may use information about you to contact you in an effort to raise money for CCDOH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at CCDOH.

Your Rights

You Have a Right to:

- **Request restrictions:** You have the right to request a restriction or limitation on the health information CCDOH uses or discloses about you. CCDOH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, CCDOH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that CCDOH send you information at an alternative address or by alternative means. CCDOH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the PHI. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If CCDOH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that CCDOH correct or add to your health record. CCDOH will respond to your request within 60 days, with up to a 30-day extension, if needed. CCDOH may deny the request if CCDOH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If CCDOH approves the request for amendment, CCDOH will change the health information and inform you, and CCDOH will tell others that need to know about the change in the health information.
- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, CCDOH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year. Additionally, CCDOH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.

● **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising CCDOH 4617 (07/17) 3 communication. You also have a right to opt-out of a CCDOH facility's patient directory, and you have the right to optout of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System for our Patients (CRISP).

● **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.

● **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.

● **Receive protection of genetic information***:* If any of CCDOH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.

● **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, CCDOH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

For More information:
This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact: **Charles County Department of Health at 301-609-.6900.**

To Report a Problem about our Privacy Practices:
If you believe that your privacy rights have been violated, you may file a complaint.
● You can file a complaint with the Charles County Department of Health, Division of Corporate Compliance at 1-866-770-7175.
● You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. You may call the Charles County Department of Health for the contact information.
CCDOH will take no retaliatory action against you if you make such complaints.

Effective Date: This notice is effective on 11/10/2025***.***
Acknowledgement of receipt of this notice:
Patient or Authorized Representative:_____

Date:_____

Signature of Patient or Authorized Representative:_____

FINANCIAL POLICY

Please read and sign the following financial guidelines for services provided by the Charles County Department of Health. Signature indicates understanding and consent. Patients with health insurance should bring their insurance card to all visits. Please inform staff of any changes to insurance or address. Insurance on record will be billed for the services provided. Patients with private health insurance (not Medicaid or Medicare) are responsible for all charges not covered by insurance. The patient is responsible for any balance not paid by insurance, including co-pays and deductibles. Uninsured patients are required to apply for coverage (e.g., Medicaid, private insurance, etc.) if eligible. The Charles County Department of Health (CCDoH) provides assistance with health insurance enrollment.

Patients that are uninsured and ineligible for Medicaid, Medicare, or private health insurance may apply to receive services through CCDOH's income-based Sliding Fee Scale Program. Applying for this program requires proof of identity and income:

1. Identification with address (e.g., driver's license, utility bill, etc.)
2. And one of the following:
    - *Pay stubs*
    - *1040 tax form*
    - *Government benefits letter*
    - *Statement of wages on company letterhead*
    - *Unemployment stubs*
    - *Letter of reference from a charitable organization*
    - *Verification of no income support letter*

A signed Financial Agreement is required for acceptance into the Sliding Fee Scale Program. Program eligibility will be determined annually. Patients reserve the right to keep income and health insurance information confidential. However, those that choose to keep this information confidential are ineligible for the Sliding Fee Scale Program and are responsible for the full cost of the health visit at the time of service.

Authorization to Release Information and Pay Insurance Benefits: I authorize CCDOH to share information about my health care with other providers who will be involved in my care and with insurance companies to make payments directly to CCDOH on my behalf.

Consent to Treatment: I wish to receive health care services from CCDOH. I understand CCHD health care professionals providing my care may determine certain tests, treatments, or consultations are required to provide appropriate care. I agree to the tests, treatments, and consultations deemed necessary.

Patient's Name:_____

Date of Consent:_____

Patient/Guardian Signature:_____