STUDENT SUPPORT UNIT
JEFFERSON PARISH SCHOOLS
822 S. Clearview Parkway
Harahan, La 70123

Dr. James Gray
Superintendent

Ajit "AJ" Pethe
Chief of Schools

School Based Health Centers of Jefferson Parish

Behavioral Health Care Only

Chateau Estates School
4121 Medoc Drive
Kenner, LA 70065
Phone:504-303-7018

Douglass Community School
1400 Huey P. Long Ave.
Gretna, LA 70053
Phone:504-371-4651

East Jefferson High School
400 Phlox Street
Metairie, La 70001
Phone:504-457-5238

Haynes Academy
4301 Grace King Place
Metairie, La 70002
Phone: 504-561-3571

Strehle Community School
178 Millie Drive
Avondale, La 70094
Phone:504-437-7920

SCAN ME
JPSCHOOLS.ORG/SBHC

For Families of Students at the Following Schools:
Chateau Estates School, Douglass Community School, East Jefferson High School, Haynes Academy & Strehle Community School

Dear Parent/ Guardian:

We are pleased to announce that our School Based Health Centers will continue to offer Behavioral Health services at five locations. Our licensed behavioral health staff will be available at school to treat your child for any behavioral health issue that may arise at school. Each school has a social worker available during regular school hours; the social worker is available to provide assessments, education, and counseling as needed. We will also have psychiatry services available by appointment.

At present, we do not have on-site medical services at Chateau Estates School, Douglass Community School, East Jefferson High, Haynes Academy, or Strehle Community School. Students registered at these locations will be able to **access medical services** at one of the locations of our partner Access Health Louisiana if needed.

The purpose of the Health Center is to keep students at school and to allow parents to stay at work. Health Centers are in numerous schools around the state and have been providing services successfully to students for over 20 years.

Please fill out the attached consent form carefully if you would like to take advantage of the clinic. A parent or guardian must be the one to print and sign their name on the consent form. **Your child cannot be seen in the Health Center without a completed consent form.** If the consent form is incomplete, it will be returned for completion. The consent form will be effective for the entire time that your child is enrolled in Jefferson Parish Schools in a school that is served by the JPS School-Based Health Centers. We will send you a one page form every year to update important information.

If you have any questions, please feel free to call the Health Center or contact me directly.

Miriam Paiz-Wahl

Miriam Paiz-Wahl, LCSW-BACS
Coordinator of School Based Health Centers
Email: Miriam.Paiz-Wahl@jpschools.org
(504) 736-7356 (office)

Jefferson Parish School Based Health Center
CONSENT & ENROLLMENT FORM

SCHOOL: _____ **GRADE:** _____

STUDENT'S NAME: _____ **Social Security #** _____
Last First Middle Initial

Student's Date of Birth: _____Age ___ Student's Sex: _____

Address: _____ City: _____ Zip: _____

PREFERRED LANGUAGE: _____ English _____ Spanish _____ French _____ Other

Race: ___ White ___ Black/African American ____ Asian ____ American Indian/Alaska Native ____ Native Hawaiian/Pacific Islander

___ More than one race **ETHNICITY:** _____ Hispanic or Latino _____ Non-Hispanic or Latino

EMERGENCY CONTACTS:

Parent/Guardian 1: _____Relationship: _____ Phone: _____; _____
(Home/Cell) (Work)

Parent/Guardian 2: _____Relationship: _____ Phone: _____; _____
(Home/Cell) (Work)

Emergency Contact: _____Relationship: _____ Phone: _____; _____
(Home/Cell) (Work)

Email to Register for Parent Portal Access: _____

INSURANCE: ❒ **Medicaid** ❒ **Commercial (Private) Insurance** ❒ **No Insurance**

Name of Insurance Company: _____

Insurance/Medicaid Policy ID # _____

Circle ONE: *Aetna * Healthy Blue LA * LA Healthcare Connections * United Healthcare * Humana *AmeriHealth Caritas*

Insurance/Medicaid Group # _____ **Phone:** _____

Name of Policy Holder: _____**Relationship to Student**_____

Policyholder's Birthdate: _____ **Policyholder's Social Security #**_____

Does your insurance pay for prescriptions? ❑ **Yes** ❑ **No**

Please attach a copy of your insurance card front and back to this application for School-Based Health services.
Services are provided for students at no out-of-pocket cost to parents. Insurance/Medicaid will be billed.

Preferred Pharmacy (Name & Location) _____ Phone: _____

Student's Primary Care Provider: _____ Phone: _____

Please check if student does not have a Primary Care Provider ❑

Student's Therapist or Psychiatrist: _____Phone: _____

Student's Dental Provider: _____Phone: _____

Do you have access to a smartphone, tablet, or computer? ___ Yes ___ No Do you have WIFI access? __ Yes __ No

Please note: All patient privacy notices and Informed Consent for Telemedicine Services are available on request and posted on the School-Based Health Center page online at jpschools.org/SBHC

Student's Name: _____ **Date of Birth:** _____

MEDICAL HISTORY

PATIENT HISTORY (Please Mark any Item That Applies to Your Child's Medical History)

Check if yes ✓		Check if yes ✓		Check if yes ✓	
	ADHD		Heart Issues (e.g. Heart Murmur)		Speech Problems
	Allergies		Hearing Problem		Substance Use
	Anemia		High Blood Pressure		Stomach Problems
	Asthma		Headaches/Migraines		Smoker
	Birth Defect: _____		Kidney Problems		Seizures/Epilepsy
	Bleeding Disorders		Learning Disabilities		Thyroid Problems
	Bone or Joint Problems		Major Injuries		Tonsillitis/Strep
	Chicken Pox (if no, vaccine date)_____		Mental Health Diagnosis (e.g. depression, anxiety):_____		UTI/Urinary tract infections
	Diabetes or Pre-Diabetes		Palpitations		Vision Problem
	Dizziness/Fainting		Premature Birth		Other:_____
	Ear Infection		Shortness of breath		Other:_____

FAMILY HISTORY (Please Mark any Item That Applies to Your Family's Medical History)

Check if yes ✓		Which relative?	Check if yes ✓		Which relative?
	Alcoholism/Drug Use			Genetic Disorder: _____	
	Allergies (insects, food, drug, etc)			Heart Attack Before Age 55	
	Anemia			Heart Disease	
	Asthma			High Blood Pressure	
	Bleeding Disorders			Mental Health Problem List:_____	
	Cancer			Seizures	
	Depression-Suicide			Tuberculosis	
	Diabetes or Pre-Diabetes			Other: _____	

ALLERGIES + MEDICATIONS

STUDENT ALLERGIES

ALLERGY (List medicine, food, insect, etc allergies)	**REACTION**

STUDENT MEDICATIONS

MEDICINE NAME	**DOSE STRENGTH**	**FREQUENCY (How Often)**

Student's Name: _____ **Date of Birth:** _____

HOSPITALIZATIONS & SURGERIES	✔ IF YES	YEAR OR AGE	HOSPITAL	Reason for hospitalization or surgery
Has your child ever been admitted to a hospital for a medical condition?				
Has your child ever had surgery?				Appendectomy Tonsillectomy &/or Adenoidectomy Hernia Repair Orthopedic (type): Other Surgery (type):

BEHAVIORAL HEALTH	✔ IF YES	IF YES, PLEASE EXPLAIN
Does your child take medication for ADHD, depression, or other mental health problems?		
Are there any behavioral health issues or concerns at this time?		
Any special needs that we should be aware of?		
Has your child ever been admitted to a hospital for a mental health condition?		

JEFFERSON PARISH SCHOOL-BASED HEALTH CENTERS OVER THE COUNTER MEDICATIONS

The following over the counter medications* have been approved by the physician of the Health Center to be administered to your child by the Registered Nurse if needed:

Acetaminophen (Tylenol)	Glucose Gel or Tablets	Neosporin
Ammonia Inhalants	Guaifenesin or Guaifenesin DM	Oral Pain Relief Gel (Orajel or Anbesol)
Anti-nausea Liquid (Emetrol)	Hydrocortisone 1% Cream or Ointment	Pepto Bismol
Acid reliever for stomach (Pepcid or Zantac)	Hydrogen Peroxide	Sore Throat Lozenges
Bacitracin	Ibuprofen (Advil)	Sterile Water
Benadryl (Diphenhydramine)	Isopropyl Alcohol	Stik It Skin Adherent
Benzoin Topical	Imodium	Sudafed PE (Phenylephrine HCl 10 mg Tabs)
Betadine Solution	Loratadine (Claritin)	Tums
Caladryl Clear	Lotrimin AF	Vaseline
Calamine Lotion	Maalox	Vitamin A&D Ointment
Chloraseptic Spray	Medicaine	Visine eye drops
Cough Drops	Mylanta	Zyrtec
Debrox (Ear Wax Removal Drops)	Nasal Relief Spray	
Eye Wash Solution	Natural Tears	

*Generic forms of medication may be substituted.

I agree that this student may receive all of the medications offered at the School-Based Health Center except those which I have written here: _____

_____

_____

_____

Student's Name: _____ Date of Birth: _____

Policy & Procedure Statement:

The Jefferson Parish School Based Health Center (SBHC) will require a completed consent/enrollment form to enroll a student for services at the SBHC. This complete consent and enrollment form will be good for the student as long as they are attending school within the same school district. The SBHC may ask the parent/legal guardian to complete an annual update form. All minor children, prior to receiving services, must have a current parent consent form on file, with the following exceptions: patients who are legally emancipated or anyone 18 or older. All parent consent forms remain part of the permanent medical record. Consent forms with questionable signatures may be rejected at the discretion of the SBHC staff. A parent or guardian is defined as either a natural or adoptive parent, in case of divorce, the parent with legal custody, or a non-custodial parent if the other is unavailable. If there is no court order, either parent can consent. Foster parents may give consent for their dependents but must produce a signed document from the natural parents or court. Stepparents, grandparents, and other relatives may not give consent unless they can produce a document showing that they have legal custody.

This SBHC abides by **Louisiana Law R.S. 37:1262** for the utilization of telehealth in the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive technology.

I understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such a 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. I agree to the disclosure of SBHC information to the Office of Public Health, or its agent, in connection with the operation, funding, and ongoing monitoring of SBHCs.

Confidentiality: The SBHCs adhere to all current laws regarding the confidentiality of health services in general and specifically as they relate to services of minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between this Jefferson Parish SBHC and the student's personal medical provider upon referral for medical care. I may request a copy of the organization's Notice of Privacy Practices that describes how health information is used and shared. I understand that Jefferson Parish SBHCs have the right to change this notice at any time. I may obtain a current copy by contacting the SBHC directly or calling 504-349-8996.

Louisiana Law R.S. 40:31.3 states that: Health centers in schools are prohibited from:(1) Counseling or advocating abortion in any way or referring any student to any organization for counseling or advocating abortion. (2) Distributing at any public school any contraceptive or abortifacient drug, device, or other 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 504.568.3504.

By signing this consent, you are agreeing for the SBHC to provide **primary, comprehensive, and preventive healthcare, physical examinations, immunizations, health screenings, laboratory/diagnostic testing, STI testing and follow-up, acute care for minor illness and injury including medications, if indicated, dental care (where available), management for chronic diseases, behavioral health services, health education, and prevention, case management, referral and follow-ups for emergencies, referral to specialty care, risk assessments, and telehealth services.**

I, as a legal parent/guardian, understand that I will not be charged for any of the services provided at the SBHC. I also understand that Jefferson Parish SBHCs, Access Health Louisiana, or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Jefferson Parish SBHCs and/or Access Health Louisiana. I understand that the SBHC is operated by Jefferson Parish Public School System and its employees and contractors, Access Health Louisiana.

My signature below acknowledges that I give permission for this student to receive the services provided by the SBHC. This consent is effective while the student is enrolled at a public school in this school district unless the SBHC is notified in writing that I no longer wish for the student to receive services.

_____ _____

Printed Name of Parent/Legal Guardian (or Student over age 18) Relationship to Student

_____ _____

Signature of Parent/Legal Guardian (or Student over age 18) Date

A duplicate copy of this document may be given to the parents or guardians upon request, on our website jpschools.org/sbhc ***or by scanning .***