Elma School District #68

1235 Monte Elma Rd - Elma, Washington 98541 - Telephone (360) 482-2822 - Fax (360) 482 - 1800

2024–2025 School Year

Dear Parents/Guardians:

Elma Middle School is partnering with local healthcare providers to bring a School-based Health Center (SBHC) to the school building. Health services are available to all Elma Middle School students. The SBHC is operated by Capital Region ESD 113 in partnership with Summit Pacific Medical Center, Elma Family Dental, and EYE See Clinic. The SBHC is staffed by a Student Assistance Navigator to coordinate care and a Prevention Intervention Professional to provide prevention and early intervention mental health services to students. School-based health services are available through in-person appointments. The SBHC offers a child-friendly setting for your student and many of the same services found in a community-based health clinic. SBHC appointments will be available before, during, and after school to accommodate student and family schedules. Every effort will be made to schedule health care appointments during non-academic time.

The SBHC will offer the following services:

- Well-child checks, immunizations, and sports physicals
- Evaluation and treatment of common health problems
- Medication management
- Prevention and early intervention mental health services
- Oral health care, including screenings, exams, cleanings, treatment, and referrals
- Vision screenings, eye exams, and glasses
- Preventative health care, including health education and promotion
- Health insurance eligibility and enrollment assistance
- Referrals to other health care providers and specialists as needed

Please select which services you are interested in enrolling your child in; the Student Assistance Navigator will follow-up with you to confirm which services you have consented for and collect any additional information needed prior to the service date:

☐ Medical
☐ Oral Health Screening
☐ Dental
☐ Vision (Screening and/or Eye Exam)
☐ Prevention and Early Intervention Mental Health

SBHC forms can be returned to the school's main administrative office. Please do not return them to your teacher.

The SBHC's healthcare partners are committed to serving all patients, regardless of ability to pay. The SBHC receives support from the Rural Health Care Services Outreach Grant Program, but this funding does not fully cover the program's operating costs; therefore, the SBHC partners will bill health insurance providers when appropriate for eligible services. Please complete the health insurance section of the registration form. If you do not have health insurance, the SBHC's Student Assistance Navigator can help you enroll in an insurance plan.

Elma Middle School is fortunate to have access to an SBHC and I hope you will take advantage of this resource for your child. If you would like more information or need assistance in completing your SBHC registration forms, please call the SBHC at: 360-482-1815 or email ElmaElementarySBHC@esd113.org.

Sincerely,
Tatia Holme, Principal

Elma Middle School-Based Health Center

Patient Registration Form

Please complete this form to allow the Elma Middle School-based Health Center care team to provide your child with high-quality healthcare services. This consent will remain active for the duration of the time that your student is enrolled in Elma Middle School. If you choose to withdraw consent for services, please submit your request in writing to the School-based Health Center.

1. Student Information and Demographics

Last Name:	First Name:	Middle Name:
Student ID Number:	Date of Birth: (Mo/Day/Yr)	Sex: (Assigned at Birth)
Mailing Address: (street or PO Box, city, state, zip)		
Physical Address: (if different from mailing address)		
Race or family background: ◯ American Indian/Alaska Native ◯ Native Hawaiian ◯ Asian ◯ Other Pacific Islander ◯ Black/African American ◯ White ◯ More than one race ◯ Decline to identify		
Hispanic or Hispanic-Latino: ◯ Yes, Hispanic or Latino ◯ No, Not Hispanic or Latino ◯ Decline to identify		
Language(s) spoken at home:		

2. Parent/Guardian Information

Last Name:	First Name:	Relationship to Patient:
Mailing Address: (if different from patient)	Date of Birth: (Mo/Day/Yr)	Sex: (Assigned at Birth)
	Parent Phone:	Parent Email Address:
	Appointment Notification Preference: (select one) ◯ Text ◯ Call ◯ Email	
Preferred Language:	Would you like an interpreter for appointments? ◯ Yes ◯ No	
Employment Status: ◯ Full Time ◯ Part Time ◯ Seasonal ◯ Self Employed ◯ Not Employed ◯ Retired ◯ Student ◯ Active Military Duty ◯ Full-time caregiver ◯ Decline to identify		

3. Emergency Contact Information (other than parent/guardian listed)

Last Name:	First Name:	Relationship to Patient:
Mailing Address: (street or PO Box, city, state, zip)		Phone:

Elma Middle School-Based Health Center

Patient Registration Form

Employment Status:
◯ Full Time ◯ Part Time ◯ Seasonal ◯ Self Employed ◯ Not Employed ◯ Retired ◯ Student ◯ Active Military Duty ◯ Full-time caregiver ◯ Decline to identify

4. Insurance Information

Do you have health insurance? ◯ Yes ◯ No	If not, would you like to receive health insurance enrollment assistance? ◯ Yes ◯ No	
Name of Insurance Carrier:	Effective Date:	Subscriber/Policy Holder Name:
Group Plan Number:	Member ID Number:	Subscriber Date of Birth: (Mo/Day/Yr)

5. Release and Consent Signature

I certify that the School-based Health Center registration information that I have provided is currently correct and I understand that any deliberate misrepresentation of the information may cause me to be responsible for the full charge of services delivered. I grant permission to the medical, mental health, and dental staff to employ established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my child's health concerns. I understand that medical care may be given by a Physician, Nurse Practitioner, Physician Assistant, or other licensed staff. I understand that the mental health care may be given by Licensed Mental Health Counselor, Social Worker, or other non-licensed mental health professionals. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. I understand that vision care may be given by a licensed Optometrist, or a trained optometry student supervised by a licensed Optometrist. This authorization shall remain in effect unless the consent is cancelled by written notice. This assignment and release authorizes the Elma School-based Health Center partners (ESD 113, Summit Pacific Medical Center, Olympic Valley Clinic, Elma Family Dental, and EYE See Clinic) to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services.I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me. I agree to pay all charges that are not paid in full by assigned insurance.

This program is supported by the Health and Human Services Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Rural Health Care Services Outreach Grant Program. Award recipients are required to submit annual progress reports for the grant. In accordance with the program's assessment plan, we will report on total individuals served, demographic information, total services provided, and program performance.

Signature:	Relationship to Patient:	Date: (Mo/Day/Yr)

Elma Middle School-Based Health Center

Consent for Health Service

Elma's School-based Health Center partners must have signed consent from a parent or legal guardian before providing services to the student, except in situations where federal and/or state laws allow the student to access treatment without parent/guardian consent. This consent form only applies to the School-based Health Center services provided by Elma Middle School's partners (ESD 113, Summit Pacific Medical Center, Elma Family Dental, and EYE See Clinic) and it does not apply to the services provided by the school nurse. Students can continue to receive school nurse services without this consent form.

I herby request and authorize that: *(Please print student's name and birthdate below)*

First Name:	Middle Initial:	Last Name:	Date of Birth:

[the student named above] will receive health care services available from and deemed necessary by the Elma Middle School-based Health Center care team (ESD 113, Summit Pacific Medical Center, Elma Family Dental, and EYE See Clinic). These services may include, but are not limited to: routine medical exams, well child care, evaluation and treatment of acute illness and injuries, immunizations, mental health counseling, and dental treatment services. I understand that the School-based Health Center care team encourages family involvement in the services they provide to students. However, if I am unable to be present, authorization is given for my child to receive services in my absence. Consent is also given for referral of care and, if needed, emergency transportation to other health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Elma Middle School-based Health Center care team. This authorization does not allow services to be rendered without the student's consent unless the student is unable to consent. Elma Middle School-based Health Center partners will collaborate and coordinate care with other community-based health care providers as appropriate.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential. A few exceptions exist, for example:

1. Permission is given by the patient or parent/guardian through a signed release of information form.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under the age of 18 years old.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care team at the Elma Middle School-based Health Center, including exchange of information between the mental health professional, medical provider, dental provider, and the school nurse and school counselor, for the purpose of providing the best care for the student. To facilitate coordination of care, the student's School-based Health Center health record will be accessible to all School-based Health Center care team members, including the Student Assistance Navigator, mental health professional, medical provider, and dental provider. Consent is granted for the school nurse to administer over-the-counter medications as prescribed by the medical provider of the School-based Health Center. Consent is authorized for services provided by the Elma Middle School-based Health Center care team (ESD 113, Summit Pacific Medical Center, Elma Family Dental, **Olympic Valley Clinic,** and EYE See Clinic) during the length of time the student is enrolled in Elma Middle School. Withdrawal of this consent can be done at any time by writing to the Elma Middle School-based Health Center.

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

Name of Legally Responsible Guardian (Print): _____ **Relationship:** _____

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the School-based Health Center (SBHC) will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages each student to involve his/her parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians. Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlaw help.org and search "Minor Consent".

Date: _____

Olympic Valley CLINIC

Pediatric Initial History Questionnaire

Patient Name: _____ DOB: _____ Age: _____ Nickname: _____

Full Names of Mother/Father/Guardian: _____

Previous Primary Care Provider: _____

Main reason for today's visit: _____

_____

Pharmacy: _____ Allergies: _____

Medical History

Diagnosis	Date Diagnosed	Care Provider	Medications/Therapies for diagnosis

Surgical History

Date	Surgery	Provider/Hospital

Hospitalizations

Date	Reason	Provider/Hospital

Other Medications (Vitamins, herbal supplements, and over-the-counter medications)

Medication	Dosage	Prescribing Provider

Family Medical History

Diagnosis	Date Diagnosed	Care Provider	Medications/Therapies for diagnosis

Elma Middle School-Based Health Center

Dental Screening Form

Dear Parent or Guardian,

We are offering dental screenings at Elma Middle School to inform you about your child's dental health. The screenings have ***no out-of-pocket costs to you***. If you consent to have us screen your child, your child will receive two dental screenings during the school year. The first will be in the fall and the second will be in the spring. We will send you a copy of your child's dental screening results. If needed, we can give you information to make a follow-up dental appointment or we can make the appointment for you, if you need help finding a dentist.

What is a dental screening?

A dental provider from Elma Family Dental will look at your child's teeth and make a visual evaluation. They will also apply a fluoride varnish on your child's teeth, which is a protective coating that is painted on teeth to help prevent new cavities and it can help slow existing cavities that have already started. A dental screening does not take the place of a complete dental exam by your child's dentist.

Parents or Guardians, please fill out the information below and sign the consent form to have your child take part in these school-based health services.

Student's Last Name:	Student's First Name:	Student's Middle Name:
Student's Date of Birth: (Mo/Day/Yr)		**Student's Sex:** (assigned at birth)

Parent/Guardian Last Name:	Parent/Guardian First Name:	Parent/Guardian's Middle Name:
Mailing Address: (street or PO Box, city, state, zip)	**Parent/Guardian Date of Birth:** (Mo/Day/Yr)	Relationship to Patient:
	Parent/Guardian Phone:	Parent/Guardian Email Address:
Preferred language for dental screening follow-up:		
How would you like to receive your child's dental screening evaluation results? ◯ Please give them to my child at school to take home ◯ Please mail them to the address listed		

This form continues on the next page. Please complete all sections.

Elma Middle School-Based Health Center

Dental Screening Form

Continued from previous page.

When did your child last see the dentist?

◯ Less than 6 months ago ◯ Less than 1 year ago ◯ Less than 2 years ago ◯ More than 2 years ago
◯ I don't know ◯ Never

Does your child have a regular dentist?

◯ Yes ◯ No If yes, who is your dental provider?

If your child does not have a regular dentist, would you like help finding a dentist?

◯ Yes ◯ No

This program is without cost to you, but your health insurance company may be billed for services. Please complete the insurance section of this form to ensure we have the most current information. Public insurance plans generally cover the entire fee of the screening. No out-of-pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's two-yearly dental exams.

Please list your Apple Health or Other Dental Insurance information below:

Name of Dental Insurance:	Subscriber/Policy Holder Name:	
	Subscriber Date of Birth: (Mo/Day/Yr)	Relationship to Child:

By signing this consent form you agree to two dental screenings and fluoride varnishes.

Signature:	Date: (Mo/Day/Yr)

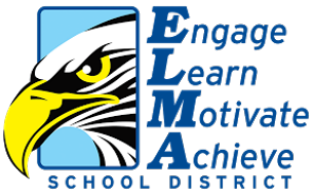
Elma Middle School-Based Health Center

Notice of Privacy Practices

Federal and State laws protect the use of personal health information and confidentiality of participants and patients. The Health Insurance Portability and Accountability Act (HIPAA) provides privacy procedures for personal health information (PHI).

The Elma Middle School-based Health Center partners (ESD 113, Olympic Valley Clinic, Elma Family Dental, Summit Pacific Medical Center, and EYE See Clinic) follow HIPAA rules and guidelines and must provide privacy protections for personal health information collected about registered participants and patients. This includes written, spoken, and electronic information.

If you want the Elma Middle School-based Health Center partner(s) to release your information to someone (relative, friend, etc.), you must sign an authorization form. For information on when we might release information without your signed authorization, such as to another health care provider, health care plan, etc. see the notice of privacy practices for all consortium partners. This detailed information is available upon request.



Elma School District #68

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Family Educational Rights and Privacy Act (FERPA) provides certain rights for parents regarding their children's education records. FERPA requires that a consent for disclosure of education records be signed and dated, specify the records that may be disclosed, state the purpose of the disclosure, and identify the party or class of parties to whom the disclosure may be made.

The Elma School-based Health Center is supported by the Rural Health Care Services Outreach Grant Program. One of the program's objectives is to explore the connection between access to health services and academics. We ask participants in this program for their consent to review and report on student educational records (e.g. attendance, student demographic information, student program enrollments, behavior, and academic achievement) to demonstrate potential connections between program participants' involvement in school-based health services and academic improvement. The purpose of this work is to share the benefit of an investment in school-based health services that will positively impact health and academics for students engaged in this program. Consent is authorized for the disclosure of my child's education records from Elma School District to Elma School-based Health Center program staff.

Name: _____

Relationship to Patient: _____

Student's Name: _____

Student's DOB: _____

Student's School: _____

Signature: _____

Date: _____

The Elma School District is an Equal Opportunity Employer. Students, families and other stakeholders are notified the district does not discriminate based on sex, race, creed, religion, color, age, national origin, sexual orientation, gender expression or identity, veteran or military status, disability, or the use of a trained dog guide or service animal in any programs or activities, and provides equal access to the Boy Scouts and other designated youth groups.

Designated to handle inquiries about nondiscrimination policies are:
504 Section Coordinator, Stacey Rockey, srockey@eagles.edu
Title IX Officer, Christopher R. Nesmith cnesmith@eagles.edu