Students

Student Health Services

School Based Health Clinic

The Newtown Board of Education (Board) endorses the placement of a School Based Health Clinic (SBHC) in some District schools. The SBHC model of health care is comprised of on-school site health care delivery by an interdisciplinary team of health professionals which can include primary care and mental health clinicians. The staff, consisting of a nurse practitioner, clinical social worker and medical assistant, shall work in cooperation with the school staff and community providers.

The mission of the SBHC is to promote the wellbeing and development of children and their families by giving priority to the unmet needs of children lacking physical, emotional, and intellectual care and nurturing. (Alternate: The mission of the SBHC is to help students learn about health practices that promote their wellbeing through an emphasis on prevention and early identification and treatment of physical and mental health conditions.

The placement of a school based health center in the middle school offers the convenience of having adolescents receive health care at the school, eliminating barriers to such care as transportation, and the lack of available or convenient appointments. The Board supports the goal of the SBHC to provide the health care that allows the child/adolescent to maximize their school experience. The SBHC, licensed by the Department of Public Health, is not the same as the school nurse's office. However, the SBHC staff and school nurse will work together to provide coordinated, comprehensive health services to students.

The School Based Health Center at Newtown Middle School:

- Is a fully licensed primary care facility providing a range of physical and mental health services, located within the school;
- Combines medical care and counseling along with health education and reinforcement of a healthy lifestyle;
- Provides additional services that work in collaboration with doctors and mental health providers in the community and is not intended to replace the family's primary care provider;
- Directs it services at, but not limited to, students who do not have access to a family doctor or whose families have little or no health insurance; and
- Provides services at no out-of-pocket costs to the family.

Students

Student Health Services

School Based Health Clinic (continued)

The medical and mental health services provided at the SBHC shall include, but are not limited to, the following:

- Diagnosis and treatment of acute and chronic illnesses;
- Physical examinations;

- Immunizations;
- Health education (nutrition, fitness) including presentation to classes
- Individual, group and family counseling (anxiety, depression, peer and family relationships, academic issues, behavioral problems, eating disorders etc.)

In order to access the services of the SBHC, the student's parent/guardian must sign the School Based Health Centers Permission Form (Form #2) and complete the Medical History form (Form #3). Services will not be provided to students unless these requirements are fulfilled. All students enrolled at the school site may use the SBHC regardless of income or health care coverage.

The confidentiality of all health information that identifies students and the treatment and services provide to them shall be maintained separately from academic records. School Staff shall not have access to medical records of students maintained at the SBHC unless written permission is given by a student's parent or legal guardian. (See Form #1-Notice of Privacy Practices)

(cf. 5125.11 - Health/Medical Records HIPAA)
(cf. 5141 – Student Health Services)
(cf. 5141.21 – Administering Medication)
(cf. 5141.22 - Communicable/Infectious Diseases)
(cf. 5141.25 – Students with Special Health Care Needs/Food Allergy)
(cf. 5141.3 - Health Assessments and School Programs)
(cf. 5141.31 - Physical Examination for School Programs)
(cf. 5141.33 – Health Records)
(cf. 5141.4 - Child Abuse and Neglect)
(cf. 5141.5 - Suicide Prevention)
(cf. 6142.1 - Family Life and Sex Education)

Students

Student Health Services

School Based Health Clinic (continued)

Legal Reference: Connecticut General Statutes
10-203 Sanitation.
10-204a Required immunizations.
10-204c Immunity from liability
10-205 Appointment of school medical advisors.
10-206 Health assessments, as amended by PA 07-58 and PA 11-179.
10-206a Free health assessments.
10-207 Duties of medical advisers, as amended by P.A. 12-198.
10-208 Exemption from examination or treatment.
10-209 Records not to be public.
10-210 Notice of disease to be given parent or guardian.
10-212 School nurses and nurse practitioners.
10-212a Administration of medicines by school personnel.
10-214 Vision, audiometric and postural screening: When required; notification of parents re defects; record of 10-217a Health services for children in private nonprofit schools. Payments from the state, towns in which children reside and private nonprofit schools.
19a-630 (10) Definitions. "Health Care Facilities"
38a-472e Health insurer. Requirements regarding offer to contract with a school-based health care center.

Department of Public Health, Public Health Code – 10-204a-2a, 10-204a-3a and 10-204a-4
Federal Family Educational Rights and Privacy Act of 1974 (section 438 of the General Education Provisions Act, as amended, added by section 513 of P.L. 93-568, codified at 20 U.S.C. 1232g).
42 U.S.C. 1320d-1320d-8, P.L. 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Approved, CIFC Board of Directors: 07/24/13

Connecticut Institute For Communities, Inc. (CIFC)
Greater Danbury Community Health Center (GDCHC)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE GREATER DANBURY COMMUNITY HEALTH CENTER ("GDCHC") MAY USE AND/OR DISCLOSE HEALTH INFORMATION ABOUT YOU, HOW YOU CAN ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

GDCHC's Commitment to Your Privacy

GDCHC is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain at GDCHC concerning your PHI. According to federal and state law, we must follow the terms of the Privacy Notice that we have in effect at the time. This Notice will take effect on August 1, 2013, and will remain in effect until it is amended or replaced by GDCHC.

GDCHC reserves the right to change its privacy practices as the law permits. GDCHC will amend this Notice to reflect any change(s) and make any new Notices available upon request. Any changes to our privacy practices will be effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of GDCHC's Notice of Privacy Practices at any time by contacting our Privacy & Security Officer, Diana Trumbley, at (203) 743-0100, or via mail at 57 North St., Suite 311, Danbury, CT 06810. You may also contact Ms. Trumbley with questions about this notice or to file a privacy/security complaint.

GDCHC WILL KEEP YOUR HEALTH INFORMATION CONFIDENTIAL, USING IT ONLY FOR THE FOLLOWING PURPOSES. PLEASE NOTE THAT THE FOLLOWING USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Treatment: While we are providing you with health care services, we may share your protected health information (PHI), including electronic protected health information (ePHI), with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, or data analysis. These business associates and subcontractors are required by Federal law to protect your health information. For example, we may ask you to have laboratory tests (such as blood or urine), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may disclose your PHI to a pharmacy when we order a prescription for you. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Additionally, everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your PHI to seek payment for services we provide to you. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatments. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, to evaluate the implementation of our compliance programs, and/or to conduct cost-management or business planning activities.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

NOTE: This is an abbreviated version of GDCHC's Notice of Privacy Practices. The full notice lists: (1) additional ways GDCHC may use your health information; (2) situations when your authorization is required for release; and (3) your rights regarding PHI. A full notice is available at all GDCHC sites. To receive a copy of the full and complete GDCHC Notice of Privacy Practices, please contact School Based Health Center Staff.

5141.29 Form 2

Registration # _____

Connecticut Institute for Communities, Inc. (CIFC) Greater Danbury Community Health Center (GDCHC)

School Based Health Centers Permission Form

All information on the front and back of this permission form must be completed, dated and signed before your child can receive services from the School Based Health Centers. If a student is 18 or older, he/she may sign his or her own permission form. Demographic information is required by the State and will be used for statistical purposes only.

Student Name (Last, First, M.I.)	Date of Birth (month/day/year)	☐ Male ☐ Female	Grade/Cluster
Street Address (Street, Town, State, ZIP code)		Home Phone Number	

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)	Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number	Work Phone Number

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)	Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number	Work Phone Number

Emergency Contact Name	Relationship to Student
Home Phone Number	Cell Phone Number	Work Phone Number

Demographic Information	Race: (Please check one) ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ More than one race	
Is the student Hispanic/Latino? ☐ YES or ☐ NO	What language(s) does the student speak? (check all that apply) ☐ English ☐ Spanish ☐ Portuguese ☐ Other:_____	In what country was the student born?
Is the student on the free or reduced lunch program? ☐ YES or ☐ NO	Family Income Per Year	Family Size

Medical Care **Please provide a copy of insurance card		**Dental Care** **Please provide a copy of dental insurance card	
Name of Doctor or Medical Clinic:		Name of Dentist:	
Doctor's Address (Street, Town, State, ZIP)		Dentist's Address (Street, Town, State, ZIP)	
Doctor's Phone Number:	Date of last physical exam:	Dentist's Phone Number:	Date of last dental exam:

Does the student have **MEDICAID/Husky Insurance:** YES or NO
Medicaid Pending: YES or NO
****Please provide a copy of the insurance card**

If your child does not have health insurance
Please call 1-877-CT-HUSKY

Medicaid #: _____

Child's name on Card: _____

Does the student have **Private/Commercial Insurance:** YES or NO
****Please provide a copy of the insurance card**

Name of Insurance Company: _____
Policy Holders Name: _____
Policy Holders Date of Birth: _____
Policy Holders Address: _____
Policy Holders Employer: _____
Relationship to student: _____
Insurance Number for the student: _____
Group number: _____

I have read the information regarding the CIFC GDCHC School Based Health Center and I give permission for this student to obtain all services offered at the School Based Health Center while he/she is enrolled in school. I understand that services are confidential, except in life-threatening situation or emergency services and accordance with the law. I give permission to the CIFC GDCHC School Based Health Centers and the Newtown Public Schools to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing. I authorize payments to be made directly to the CIFC GDCHC School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the CIFC GDCHC's privacy policy as per federal law. **Unless I choose to withdraw my consent in writing, this authorization for services at the School Based Health Centers will continue for the entire period of time this student is enrolled in Newtown Public Schools.**

Date: _____ **Signature:** _____ **Relationship to student:** _____

5141.29 Form 3

SBHC Medical History Form

Student's Name: _____ Date of Birth: _____

Is the student currently taking any medications? If yes, please list medications and dose:

_____

_____

_____

Please check "**YES**" or "**NO.**" Please explain all "YES" answers in the space provided.

Medical History:	**NO**	**YES**	**(If YES, please explain)**
Allergies (i.e. food, medication, chemicals, etc.)			
Any problems with vision (contacts/glasses)			
Any problems with hearing			
Concussion (when?)			
Fainting or blacking out			
Heart Problems/Murmurs/Chest Pain			
High Blood Pressure/Cholesterol			
Problems Breathing/Coughing/Asthma			
Blood Disease/Disorders (i.e. Anemia, Sickle Cell, etc.)			
History of Seizures			
Diabetes/Thyroid/Endocrine			
Hospitalization or Surgery			
Broken bones, dislocations, or other problems			
Muscle or joint injuries			
Neck or back injuries			
Running/exercise problems			
"Mono" (When?)			
TB or Positive skin test			
Dental Problems			
Headaches or Migraines			
Weight or Eating issues			
Has only one kidney or testicle or eye			
Females: Menstrual problems			
Other medical problems not addressed above:			

Mental Health History:	**NO**	**YES**	**(If YES, please explain)**
Anxiety			
Mood disorder/depression			
Loss/divorce issues			
ADHD/ADD/Learning Disorder			
Autism/Aspergers			
Eating disorder/weight problem			
Cutting/self-mutilation			
Smoking/Alcohol Use/Drugs			
Other mental health/behavioral problems:			

Family History:	**NO**	**YES**	**Relative (who?)**	**(If YES, please explain)**
Death of a relative under age 50				
Family members with heart disease, high cholesterol and/or diabetes (which?)				
Alcohol/Drug Problems				
Mental Illness (i.e. Depression)				
Any other family medical problems not addressed above				
Any other family issues not addressed above				
Is the student under the care of any medical specialist (Explain)				

If you would like to speak with one of the School Based Health Center staff members regarding concerns you may have about your child, or for general SBHC questions, please call during school hours:

Newtown Middle School SBHC Phone: (203) 270-6114
Fax: (203) 270-4644

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

Date: _____ **Signature:** _____ **Relationship to student:** _____