Dear Parents/Guardians:

The Wilmington Charter/Cab Calloway School-Based Health Center (SBHC) is a partnership between Christiana Care Health Services, Red Clay School District, and the Delaware Division of Public Health. This letter is an invitation to sign up your child in the SBHC.

Health care in the SBHC is provided by a multi-disciplinary team. A Nurse Practitioner, a Licensed Clinical Social Worker/Licensed Professional Counselor of Mental Health, and a Registered Dietitian provide care at your child’s school. We invite you to select all services that your child may need during their years in high school.

To sign up your child in the SBHC:

- Up-to-date insurance information is needed if your child is insured. No co-pay, co-insurance or deductible will be charged to you and no one will be turned away based on ability to pay.
- Please review, fill out and sign the attached Consent Form choosing which services your child has permission to receive while they are students at Wilmington Charter/Cab Calloway High Schools.
- Fill out attached Student Registration Form and Health History Form
- Return completed enrollment/registration forms to the SBHC

SBHC services offered:

- Counseling (individual, family, and group)
- Health education/risk reduction
- Crisis intervention and suicide prevention
- Nutrition/weight management
- Pregnancy testing
- Diagnosis and treatment of sexually transmitted diseases (STDs)
- HIV testing at approved high schools
- Reproductive Health Services (Birth control pills/Depo-Provera/condoms) available at approved high schools
- Physicals (sports, school, or pre-employment)
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses/injuries
Please know that your child’s pediatrician or family doctor is still your child’s main doctor. SBHC does not take the place of your child’s pediatrician or family doctor, and SBHC doctors and nurses will work with your child’s main doctor to care for your child. The SBHC offers services that may round out the care provided by your main doctor. When appropriate, and with your permission, we will try to share medical information with your child’s doctor to prevent any duplication of health care services, and to take the best care of your child. If your child does not have a doctor, we can help you find one.

The SBHC staff thanks you for your time. Together with you and your child’s main doctor, we will work towards keeping your child healthy and in school. Please encourage your child’s pediatrician or family doctor to call the SBHC with questions. If you have questions or need more information, please call the Wilmington Charter/Cab Calloway School-Based Health Center at (302) 651-2100.

Sincerely,

Martha Coppage-Lawrence, CPNP, Site Coordinator
302-651-2100
Kathy Cannatelli, MS, Administrative Director
Mary Stephens, MD, Medical Director
302- 320-6557
SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES

I, ________________________________ (Parent/Legal Guardian of Student), give my consent for __________________________ (Name of Student) to receive health services at the Wilmington Charter/Cab Calloway School-Based Health Center administered by Christiana Care Health Services Telephone Number: 302-651-2100

If your student should request any of the following services, do they have your permission to receive them?

<table>
<thead>
<tr>
<th>MENU OF SERVICES</th>
<th>CONSENT GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL HEALTH</strong></td>
<td>(CIRCLE ONE)</td>
</tr>
<tr>
<td>• Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury (May include a urinalysis, throat culture, limited blood tests, dispensing non-prescription medication and/or providing prescription medication)</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Physical examinations, including sports/employment physical</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Immunizations in accordance with the Division of Public Health</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Diagnosis and treatment of sexually transmitted diseases</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Nutrition counseling</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Pregnancy screening</td>
<td>YES NO</td>
</tr>
<tr>
<td>• HIV Testing</td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td>YES NO</td>
</tr>
<tr>
<td>• Individual counseling</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Group counseling</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Family counseling</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Drug, alcohol and other substance abuse counseling and referral</td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td>YES NO</td>
</tr>
<tr>
<td>• Individual and group programs focusing on healthy life choices</td>
<td>YES NO</td>
</tr>
<tr>
<td><strong>REPRODUCTIVE HEALTH</strong></td>
<td>YES NO</td>
</tr>
<tr>
<td>• Condoms</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Oral Contraceptives</td>
<td>YES NO</td>
</tr>
<tr>
<td>• Depo-Provera</td>
<td>YES NO</td>
</tr>
</tbody>
</table>

**CONFIDENTIAL SERVICES**
The following confidential services are offered by this School-Based Health Center. If you consent to your child receiving confidential services at the School-Based Health Center, then according to Delaware Law (Title 13 §710) you do not have the right to information about these services unless your child gives the School-Based Health Center permission to share that information.

• Pregnancy testing
• Diagnosis and treatment of sexually transmitted diseases
• Condoms
• Oral Contraceptives
• Depo-Provera
• HIV Testing

The School-Based Health Center does not provide the following services
• Treatment or testing of complex medical or psychiatric conditions
• Ongoing primary treatment of chronic medical conditions
• Complex lab tests
• Hospitalization
• X-Rays

PLEASE COMPLETE OTHER SIDE
I understand that the Delaware Division of Public Health (“DPH”), a division of the Department of Health and Social Services, retains administrative authority over, and provides partial funding for, the School-Based Health Center. Designated School-Based Health Center team members are obligated by law to disclose specific patient information to DPH, for the purpose of preventing or controlling disease, injury, surveillance, or disability in Delaware as well as in the United States. Such information mandated and required by law includes: sexually transmitted disease; laboratory data; births; deaths; adverse medication reactions; child abuse or neglect; and domestic violence. Other general information will also be sent to DPH for statistical tracking, but this information will be de-identified which means that my student’s name will be removed.

I have had the opportunity to receive and review the Christiana Care Health Services’ Notice of Privacy Practices brochure.

I understand that the School-Based Health Center may use telemedicine to provide mental health services. The video conference between student and mental health provider does not involve data storage, recording, or archiving. Telemedicine encounters would still be subject to the requirements of the HIPAA Privacy Rule that applies to Protected Health Information.

I understand that insurance may be billed for covered services and the need to provide insurance information before services are provided.

I understand that the School-Based Health Center shall not charge co-pays or any other out-of-pocket fees for use of School-Based Health Center Services.

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the School-Based Health Center associated with my student’s care.

I acknowledge that all information requested on the registration Health History Form and this consent is accurate and complete. My student and I have read this form carefully and I understand that if I have any questions I may call the School-Based Health Center Coordinator for any explanation(s) before I sign this authorization.

By my signature below I certify, as the parent or legal guardian of the student named above, I understand the School-Based Health Center consent for treatment.

__________________________                   _________________________
Signature of Parent/Legal Guardian            Date

__________________________
Print Name of Parent/Legal Guardian

__________________________                   _________________________
Signature of Student                          Date

__________________________
Print Name of Student

__________________________
Street Address

__________________________  __________   __________
City                State        Zip Code
Patient Registration Form

### Patient (Student) Information – Please Print (in pen)

<table>
<thead>
<tr>
<th>Patient’s Last Name:</th>
<th>First:</th>
<th>Middle:</th>
<th>Grade:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Birthdate</th>
</tr>
</thead>
</table>

**Race** (please circle all that apply):
- Caucasian/White
- Black/African American
- Asian/Native Hawaiian/Other Pacific Islander
- American Indian/Alaskan Native

**Ethnicity** (please circle):
- Hispanic/Latino
- Arabic
- Non-hispanic/latino/arabic

**Primary Care Physician (Family Doctor)**

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Phone Number: ____________________________</th>
</tr>
</thead>
</table>

**In case of an emergency contact:**

<table>
<thead>
<tr>
<th>Relationship to patient: ____________________________</th>
<th>Phone #: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is patient employed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Parental/Legal Guardian Information

**Mother’s Full Legal Name:**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Home Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent Email Address:</th>
<th>Cell Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Name &amp; Address:</th>
<th>Work Phone#:</th>
</tr>
</thead>
</table>

**Father’s Full Legal Name:**

<table>
<thead>
<tr>
<th>Address:</th>
<th>Home Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Name &amp; Address:</th>
<th>Work Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Legal Guardian Name (if not mother or father):</th>
<th>Relationship to Student</th>
<th>Home Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Cell Phone#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Name &amp; Address:</th>
<th>Work Phone#:</th>
</tr>
</thead>
</table>

### Insurance Information (REQUIRED) – Send in a Copy Front and Back of Insurance Card

**Source of payment for care, please check off one of the following:**

- [ ] No Insurance
- [ ] Medicaid: (Please circle)
  - United HealthCare or Health Options/Highmark State Plan
  - Medicaid Number: ____________________________
  - Commercial Insurance: ____________________________
    - Policy Number: ____________________________
    - Subscriber Name: ____________________________
    - Relationship to Student: ____________________________
    - Subscriber Birthdate: ____________________________
- [ ] Delaware Healthy Children Program

**Secondary Insurance Information:**

<table>
<thead>
<tr>
<th>Medicaid: (Please circle)</th>
<th>United HealthCare or Health Options/Highmark Neither</th>
</tr>
</thead>
</table>

| Medicaid Number: ____________________________ | Commercial Insurance: ____________________________ |

| Policy Number: ____________________________ | Subscriber Name: ____________________________ |

| Relationship to Student: ____________________________ | Subscriber Birthdate: ____________________________ |

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*Note: Please fill out all sections as applicable.*
A complete and accurate health history is needed in order for Center staff to provide high quality care. Services will not be provided unless this form is complete. **A Parent/Legal Guardian must complete this form in pen.** Please print all information.

Student’s Name _________________________  DOB________________ Grade ________  □ Female  □ Male

(Last) (First) (MI)

Does your child have any allergies? (food, medication, latex)

□ Yes  □ No  If yes, please list?

Please provide the following information about medicines your adolescent is taking.

<table>
<thead>
<tr>
<th>Name of medicines</th>
<th>Reason taken</th>
<th>How long taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your adolescent ever been hospitalized overnight?

□ Yes  □ No  If yes, give the age at time of hospitalization and describe the problem.

Age

Problem

Has your adolescent ever had any serious injuries/illness?

□ Yes  □ No  If yes, please explain.

Has your child been seen by a health care provider in the past year? Name of provider: _____________________________

□ Yes  □ No  If yes, please indicate the number of visits: ________  Phone#: _____________________________

Reason(s) for visit(s): ________________________________________________

Has your child been seen in an emergency room within the last year?

□ Yes  □ No  If yes, please indicate the number of visits: ________

Reason(s) for visit(s): ____________________________________________

Has your child been seen for a dental visit in the last year?

□ Yes  □ No  Name of Dentist: _____________________________

Has your child ever been hospitalized or received counseling for emotional health?

□ Yes  □ No  If yes, when?  ____________________________  Where?

Reason: ____________________________________________

PLEASE COMPLETE OTHER SIDE
Please indicate which of the following your **CHILD** has ever had:

- Acne/Skin Problems
- ADHD/learning disability
- Anemia
- Anxiety
- Arthritis
- Asthma
- Cancer
- Chicken Pox
- Cystic Fibrosis
- Diabetes
- Depression
- Frequent Colds
- Headaches
- Head Injury
- Heart Disease
- Heart Murmur
- Hemophilia
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Kidney/Bladder Disease
- Pregnancy/Child Birth/Miscarriage
- Rheumatic Heart Disease
- Scoliosis
- Seasonal Allergies
- Seizures
- Sickle Cell
- Sleeping Problems
- Sports Injury
- Stomach/Intestinal Problems
- Suicide Attempts
- Suicidal Thoughts
- Substance Abuse
- Thyroid Disease
- Tuberculosis

If any of the above is checked, please give more detail.

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In the **past year**, have there been any changes in your family such as:

- [ ] Marriage
- [ ] Serious Illness
- [ ] Change in school
- [ ] Births
- [ ] Divorce
- [ ] Separation
- [ ] Loss of Job
- [ ] Move to a new house
- [ ] Deaths
- [ ] Other

Please check any of the following illnesses that your **FAMILY MEMBERS** (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and indicate which family member next to the illness.

- [ ] ADHD/learning disability
- [ ] Alcoholism/Drug Abuse
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Birth defects
- [ ] Cancer
- [ ] Cystic Fibrosis
- [ ] Deafness
- [ ] Diabetes
- [ ] Headaches
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Cholesterol
- [ ] Kidney/Bladder Disease
- [ ] Mental Illness
- [ ] Obesity
- [ ] Seizures
- [ ] Sickle Cell
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Unexplained Death
- [ ] Other

**PARENTAL/GUARDIAN CONCERNS**

Below are some common concerns of adolescents and families. If you have any of these concerns, please encourage your child to schedule a visit at the Wellness Center or you can feel free to call the Wellness Center to discuss your concerns.

- Weight/Diet/nutrition
- Sleep Patterns
- Smoking cigarettes/chewing tobacco
- Choice of friends
- Self image/self worth
- Depression
- Lying, Stealing, or vandalism
- Violence
- School grades truancy/dropout
- Relationships with family members
- Drug/Alcohol use
- Sexual behaviors
- Sexual identity
- Excessive moodiness or rebellion

If you would like assistance with establishing Insurance, finding a doctor, or a dentist, please call the School-Based Health Center.

Name of person completing this form: ________________________________

Relationship to student: ________________________________ Date: ________________
NOTICE OF PRIVACY PRACTICE

Effective Date: September 23, 2013

This Notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully. If you have a question, contact the Privacy Officer at (302) 623-4668.

Our promise
We know that your medical information is very personal. We do our best to protect the privacy of your medical information. We will only use and disclose your information as allowed by applicable law.

We are required by law to maintain the privacy of your health information and to provide you with this Notice of Privacy Practices. Please read this Notice carefully. It will help you understand your rights regarding your health information. If you have any questions about this Notice, please call or write to the Privacy Officer at (302) 623-4668.

We will use and disclose medical information about you to provide you medical care. We may use and disclose medical information about you to doctors, doctors in training, nurses, students or other people in the hospital who are part of your care here. We may also give medical information to work with people outside the hospital who provide care for you.

To get paid. We may use and give out health information about you so that the care you receive here will be paid by you, an insurance company, or other payers. For example, we may bill your health plan about care you received, as it can pay for that care. We may also tell your health plan about care you are going to get to find out if they will pay for that care.

To run Christiana Care. We may use and give out medical information about you to run Christiana Care. We may also use your information to see how we took care of you and how you did. We may also put together medical information about many patients to decide if there are other services Christiana Care should offer, what services are needed or not needed, and what new treatments are effective. People taking care of you, including doctors, nurses, and students, may receive information for learning purposes. Information may be combined with medical information from other hospitals to compare how we are doing and see if we can improve the care and services we offer.

Funding activities. We may contact you to ask for a donation. We have the right to use certain information for this purpose (including your contact information, age, gender, dates of service, department of service, treating physician, outcome information and health insurance status). If you do not wish to be contacted for our fundraising efforts, you may opt out by calling 1-800-493-2273, sending an email to giveback@christianacare.org or writing to the Christiana Care Office of Development, 13 Reads Way, Suite 203, New Castle, DE 19720. We will not use the information for fundraising if you request not to be contacted.

Hospital directory. If you are a patient in our hospital, we may include limited information about you in the hospital directory so your friends, family and clergy can visit you and find out how you are doing. This information may include your name, location in the hospital, phone number, and your religious affiliation. All information except for your religious affiliation may be given to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, even if they don’t ask for you by name. We may also tell that a patient has died after next of kin has been told. If you do not want anyone to know about you, you must sign a form that will be provided to you when you are admitted.

Family and friends. We may give medical information about you to a friend or family member who is involved in your health care. This would include persons who are involved in your medical care. This would include persons named in any health care power of attorney or similar document given to us.

We may also give information to someone who helps pay for your care. In addition, we may give out medical information about you to an agency that helps with public safety or disaster relief efforts so that your family can be contacted about your condition, status, and location.

Research. In most cases, we will ask for your written approval before using your medical information or sharing it with others in order to carry out research. However, we may use and give your health information without your approval in the following ways:

As required by law. When we are required to do so by federal, state, or local law.

To help avoid a serious threat to health or safety. To help avoid a threat to the health and safety of you, the public or another person.

Organ and tissue donation. To agencies that handle organs, eye, and tissue donations, or to an organ donation bank so these organizations may assist transplantation.

Military and veterans. If you are a member of the armed force, we may release medical information about you as required by military command authorities. We may give information to the Department of Veterans Affairs to find out if you can get certain benefits.

Workers’ compensation. We may share information to assist programs that provide benefits for work-related injuries or illness.

Public Health authorities. We may provide information for Public Health activities, such as reporting disease outbreaks; births and deaths; child abuse and other reactions to medications; recall notifications; or communicable diseases.

Health oversight activities. We may provide information to agencies monitoring the health care system or government programs or making sure hospitals are following the law. These activities include audits, investigations, inspections, and licensing.

Law enforcement. If we are asked to do so by law enforcement officials we are required to do so by law:

In response to a court order, subpoena, warrant, summons, or other similar process.

To identify or locate a suspect, fugitive, material witness, or missing person.

To report the victim of a crime if, in certain cases, we are unable to get the person to agree.

To report about a death we think may be the result of criminal conduct.

To report criminal conduct in our facility.

In emergency cases to report a crime, the location of the crime or victim, or the identity, description, or location of the person who committed the crime.

Deceased Individuals, Coroners, medical examiners, and funeral directors. We may provide information to a coroner or medical examiner to

21348 5(87355)[1013]
identify a person who has died or find out why the person died. We may also give out medical information to funeral directors. We will protect the confidentiality of your medical information for 50 years following your death.

• National security and intelligence activities. We may provide information to authorized federal officials for national security activities authorized by law. This includes the protection of the President or foreign heads of state.
• Prisoners. If you are a prisoner of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the prison or law enforcement officials when necessary for your health and safety or the health and safety of others.

Delaware Health Information Network (DHIN)

We take part in a health information exchange called DHIN to help us share your health information with other doctors and health care organizations that take care of you and to get information from those other persons involved in your care. This allows each of us to provide better care and to coordinate your care. Information on DHIN’s privacy practices is available on its website: www.dhin.org/consumer.

To contact DHIN, call (302) 679-0220.

When we need your written permission to give out your medical information

We will need your written permission to use or give out your medical information for any reasons that do not fall within the categories described above in this Notice. Specifically, we need your permission to use or release psychotherapy notes, to use information for marketing or to sell health information.

If you give us permission, you may take back that permission, in writing, at any time. If you take back your permission, we will no longer use or share medical information about you, except for those activities and purposes not requiring your permission—such as to take care of you, get paid, and run Christiana Care. You understand that we are unable to take back any information we have already shared with your permission and that we have to keep records of all the care that we have given you.

Your rights regarding medical information about you

• Right to look at and get a copy. Most of the time, you have the right to look at and get a copy of your health information that may be used to make decisions about your care. To look at or get a copy of your health information, please write to Health Information Management Services.
• Right to request a correction. If you believe that your health information is incorrect or incomplete, you may ask us to correct it or complete it. Correcting means changing incorrect or incomplete information. We may deny your request if it is not about information that we created and you, or someone else on your behalf, submitted to us, if it is not to your health information, or if the information was accurate and complete.

On rare occasions, we may not be able to let you see or get copies of your records. If this happens, we will tell you the reason and you will have the right to request review of that decision.

• Right to amend. You have the right to ask for an amendment of information that is incorrect or incomplete for as long as the information is kept by the hospital. To ask for an amendment, you must write to the Privacy Officer and provide a reason. We may deny your request if we think the amendment:
• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
• Is not part of the information that you would be permitted to inspect and copy.
• Is accurate and complete.
• Right to a list of disclosures. You have the right to request an “accounting of disclosures” or a list of who outside of the hospital has received information about you. This does not apply to information given to take care of you, for Christiana Care to get paid or to run Christiana Care.

To ask for this list, you must put your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years. The first list you ask for within a 12-month period will be free. If you want more lists, we may charge you for the costs of providing the list. We will tell you the costs and get your approval before we mail the list.

• Right to notification of a breach. You have the right to receive notice if there is a breach of your unsecured protected health information (that is, an unauthorized acquisition, access, use, or disclosure of protected health information that compromises the security or privacy of the information). This notice may be given by mail or through the news media.

• Right to restrictions. You have the right to ask us to limit the medical information we use or give out about you. We are not required to agree to your request. We may deny your request if it would adversely affect your treatment, payment, or your health information is subject to a legal duty. We will consider your request based on the information provided by you and the health care you are receiving.

• Right to a copy of the Notice. To get a copy of this Notice, ask for a copy from Patient Registration or the Privacy Officer.

Changes to this Notice

We have the right to change this Notice. All changes to this Notice will apply to information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the hospital and on our Web site: www.christianacare.org.

If we make material changes to this Notice, we will provide you with the updated Notice at your next visit.

Complaints

If you think your privacy rights have been violated, you may file a complaint with us by writing to the Christiana Care Privacy Officer. Please provide enough detail to allow us to look into the matter.

You may also file a complaint with the Office of Civil Rights at:


PLEASE NOTE: You will not be treated any differently for filing a complaint.

How to contact us

If you have any questions about this notice or if you need to make a request to the Privacy Officer, please contact us at:

Christiana Care, c/o Privacy Officer, PO Box 6001, Newark, DE 19718-6001 (302) 623-4468