Walsh Intermediate School

185 Damascus Road, Branford, CT 06405

Welcome to the School Based Health Center!

The School Based Health Center, a partnership between the Branford Board of Education and Yale-New Haven Hospital, is a free-standing medical center licensed by the state of Connecticut and located in the Walsh Intermediate School Health Office. Our staff is available to provide medical and mental health services to ALL children enrolled at Walsh Intermediate School. Students, regardless of family income or health care insurance, are eligible to use the clinic. Yale-New Haven Hospital will bill insurance companies for some of the services rendered; however there is no fee for using the School Based Health Center. Once enrolled, students are registered for the four years that they attend Walsh.

The School Based Health Center Staff believes it is important that each child has a health care provider outside of school and we work to strengthen that relationship. We ensure seamless, continuous care between your child, your health care provider and the School Based Health Center.

Available Services:

- School, Sport & Camp Physicals
- Treatment of Injuries
- Preventitive Health Care
- Individual, Family & Group Counseling
- Illness Visits
- Immunizations
- Nutrition Counseling
- Adolescent Health Care

We are located in the HEALTH OFFICE at Walsh Intermediate School

Enrollment Information

Our School Based Health Center is committed to treating each child at Walsh Intermediate School in a comprehensive and confidential manner. The health center staff works closely with the school nurses and other key school personnel to offer health care that is in the best interest of your child. The center is open while school is in session. In order to enroll your child, parents and guardians MUST complete and sign the center's permission form.

HEALTHY KIDS MAKE BETTER LEARNERS
SCHOOL BASED HEALTH CENTERS

Branford SBHC's are satellite clinics of Yale-New Haven Hospital.

YALE-NEW HAVEN HOSPITAL

Questions?

Please feel free to call the number on the below and we will be happy to speak to you and answer any questions that you may have.

SBHC Information

Phone: (203) 315-3533
Fax: (203) 315-7094

See our link, School Based Health Center, at **www.branford.k12.ct.us** Click on Walsh Intermediate School.

To be filled out by the SBHC Staff. **Referred by**_____

Medical Record#_____ **ID# (to be assigned by SBHC):**_____

WALSH INTERMEDIATE SCHOOL
SCHOOL-BASED HEALTH CENTER PERMISSION FORM

Please complete and sign this form and return to Walsh Intermediate School, School-Based Health Center.

Today's Date: _____ **Grade:** _____

Student's Name: _____ **Sex:** Female Male
Last First M.I.

Home Address: _____ **City:** _____ **Zip Code** _____

Student's Social Security # ____-____-____ **Birth Date** ____/____/____

Child's Ethnicity: Hispanic/Latino ____ Not Hispanic/Latino ____ **Religion** (optional) _____

Child's Race:
Black or African American _____ White _____ Asian _____ American Indian or Alaskan Native_____
Native Hawaiian/Other Pacific Islander _____ Unknown _____ Other _____

PARENT INFORMATION:

Mother:_____ **Father:**_____

Address: _____ **Address:** _____

Home Phone: _____ **Work:** _____ **Home Phone:** _____**Work:**_____

Cell: _____ **Cell:** _____

Email:_____ **Email:**_____

Parents: Married _____ Divorced _____ Separated _____ Mother Deceased_____ Father Deceased _____

Guardian of Student: _____**Relationship to Student:**_____

Address:_____

Home Phone: _____**Work Phone:** _____ **Cell Phone:** _____

Emergency Contact: (please note how the person is related to your child)

Name _____ Phone: _____ Relationship _____

Number of people in household: ___ Need Interpreter? yes ____ no____ **Preferred Language** _____

Does your child qualify for the free or reduced school lunch program? yes _____ no _____ unknown_____

Health Care Provider: Primary Care Physician _____ Phone #:_____

Dentist: _____ Preferred Pharmacy_____

Usual Source of Health Care: Community Health Center_____ Emergency Room_____ Hospital Clinic_____

School Based Health Center_____ No Regular Source_____ Private Doctor_____ Other _____

INSURANCE INFORMATION: Please provide a copy of your current insurance card(s) to the SBHC office.

Insurance Company_____ Address/Phone_____

Policy #_____Group Name and #_____

Policy Holder's Name_____ Birthdate: _____ S.S.#____-_____-_____

Relationship to Student_____

Employer Name _____ Occupation:_____

Employer Address:_____ City: _____ State: _____ Zip:_____

Phone:_____

INSURANCE TYPE (Please check one)

Husky A ___ Husky B ___ No Insurance ___ Private/Commercial ___ Unknown ___ Other_____

STUDENT'S MEDICAL HISTORY: Please circle and explain if your child has a history of the following:

Heart Problems	Heart Murmur	Dental Problems/Needs	Chicken Pox (Year:_____)
Headaches	Stomach Problems	Skin Problems	Upper Respiratory Infections
Weight Problems	Vision Problems	Ear Infections	Musculoskeletal Problems
Asthma	Allergies	Diabetes (Insulin Yes__ No__)	Other_____

Explain:_____

_____

_____

_____

Female Students:
Has your child begun menstruating? ____ Yes _____ No If no, have you discussed menstruation with her? ____ Yes ____No

Please answer the following questions. If yes, please explain. Is your child currently, or have they had -

Y N Allergies to food, medicine, or other: _____

Y N Taking medications regularly (please list medication and dose): _____

_____

Y N Hospitalizations/surgeries: _____

STUDENT'S BEHAVIORAL HEALTH HISTORY: Please circle and explain if your child has a history of the following:

Anxiety	ADHD/ADD	Alcohol/Drug Use	School Attendance Problems
Eating Disorders	Tantrums	Behavior Problems	Depression/Sadness
Academic Failure	Fighting	Worrying	Sleep Problems

Explain:_____

_____

_____

Y N **Currently in counseling:** Therapist/Provider:_____

Y N **Current Agency Involvement:** _____

Y N **History of counseling:** Dates: _____

Therapist/Provider:_____

Please note any concerns that you would like to discuss with the School Based Health Center staff:

_____

_____

_____

I give my consent for (Students Name) _____ to receive medical and/or mental health services at Walsh Intermediate School. I understand all services are confidential in accordance with Connecticut State laws, except in life-threatening or emergency situations. I give permission for the release and exchange of information between the SBHC staff and my child's health care provider. I also give permission for the SBHC staff to communicate with school personnel and to access my child's school and health record.
I authorize Yale-New Haven Hospital to bill my insurance carrier and to release information regarding my treatment and/or services for the purpose of billing. I will not be responsible for paying for any service received at the SBHC. I understand that all medical records are the property of Yale New Haven Hospital. I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I can withdraw my consent to treat at any time through written notification.

_____ _____

Parent/Guardian's Signature **Date**

06/13

Y A L E N E W H A V E N H E A L T H S Y S T E M
& YALE UNIVERSITY

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 it carefully. If you have any questions, please contact our privacy office at the phone number at the bottom of this notice.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to improve treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies. Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protection.

If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

In any other situation not covered by this notice, including the use or disclosure of psychotherapy notes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Who will follow this notice?

Yale New Haven Health System (YNHHS) and Yale School of Medicine (YSM) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of our locations
- All departments and affiliated covered entities of Yale New Haven Health System, including; Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group, and Yale-New Haven Hospital
- Yale School of Medicine
- The clinical care providers of Yale School of Nursing as well as their affiliates
- All employees, medical staff, affiliates, trainees, students, or volunteers of the entities listed above

While each of these facilities and affiliates operates independently, they may share your health information for coordination of care, treatment, payment, and healthcare operations purposes.

Right to Be Notified of a Breach:

We will notify you in the event that the confidentiality of your information has been breached.

Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in advance, in writing. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

You have the right to request a list accounting for any disclosures of your health information we have made, as required by law.

To request this list of disclosures, indicate the relevant period which must be within the past six years. You must submit your request in writing to the Medical Record or Billing Department as appropriate.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it unless all of the conditions below are met:

- You request that your information is not shared with an insurer for purposes of payment or other purposes unrelated to your treatment;
- You pay all charges associated with the services you received out-of-pocket in full; and
- We are not required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at yalenewhavenhealth.org. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

YNHHS OFFICE OF
PRIVACY AND COMPLIANCE
203-688-8416
Toll Free: 1-855-688-2424
privacy@ynhh.org

Yale University HIPAA
Privacy Office
203.432.5919
hipaa@yale.edu

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