School Based Health Center Program Description

What is a School Based Health Center?

A school-based health center is a shared commitment between a community's schools and health care organizations to support students' health, well-being, and academic success by providing preventative, early intervention, and treatment services where students are - which is at school.

Students can be treated for acute illnesses, such as flu, and chronic conditions, including asthma and diabetes. They can also be screened for dental, vision and hearing problems. With an emphasis on prevention, early intervention and risk reduction, school-based health centers counsel students on healthy habits and how to prevent injury, violence and other threats.

The existing school clinic staff will continue to manage the day-to-day oversight of school health. The School Based Health Center will complement the school clinic by being available to all students, including those without health care, and those in need of services such as primary, mental, oral or vision care. Even if your child already has a primary care doctor, he/she can still benefit from our health services should a problem arise in school.

Why are we partnering with MCR Health?

For over 40 years MCR Health has upheld the definition of community by embracing diversity and providing health care to our community and assisting those in need by collecting supplies for school children, hosting an annual holiday toy drive for underprivileged children, sponsoring sports teams, and civic clubs. MCR Health is a private, nonprofit medical group providing family practice, pediatrics, OBY/GYN, behavioral health, vision, dental and many other services. They have more than 30 health centers, three mobile units, more than 15 pharmacies and six administrative sites. They are one of the largest, most diversified Federally Qualified Health Centers in the southeastern U.S.

How will this center work?

- You must complete the attached consent form and other information pages and send back to school with your student. Your student can bring the completed paperwork to the main office ATTN: School Based Health Center.

- If your child is feeling sick or injured at school, they will continue to go to the School Clinic, and the current Department of Health School Nurse or Medical Technician will determine if your child would benefit from further care and follow up at the School Based Health Center. If you have a consent on file, they will refer you directly to the Health Center, any necessary treatment and prescriptions will be provided. If your child does not have a consent on file for the School Based Health Center, the school clinic staff will contact you.

- The School Based Health Center hours will be Monday through Friday 7:30am - 4:00pm (Behavioral Health 8am-5pm) when school is in session.

- The School Based Health Center does not take the place of your child's regular doctor and joining the program does not mean you are changing your child's doctor. You will be encouraged to have any needed follow up care with that physician and a summary of your child's visit at the School Based Health Center will be sent to your child's doctor. If your child does not have a regular doctor, then the staff and SBHC can serve in that role. If your child is already a patient of MCR Health, you will still have to sign this consent to utilize the School Based Health Center.

- You or your child may contact their school's health center **(see phone numbers below)** and schedule appointments for physicals, immunizations, required sports and/or employment physicals, or other associated health and mental concerns once we have consents on file. The SBHC will also have a schedule of when the MCR Health vision and dental van will be here so you can schedule these appointments ahead of time.

    - **DAUGHTREY ELEMENTARY CHILDREN AND FAMILY HEALTHCARE CENTER: (941) 304-3960**
    - **MANATEE ELEMENTARY SCHOOL BASED HEALTH CENTER: (941) 348-1161**
    - **MCR HEALTH SOUTHEAST HIGH SCHOOL - SCHOOL BASED HEALTH CENTER: (941) 245-0057**

Patient Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

MCR BEHAVIORIAL/MENTAL HEALTH INFORMED CONSENT FOR TREATMENT FORM

DATE: _____ **TIME: _____**

I hereby authorize MCR Health and the Behavioral Health Services staff, and whomever may be designated as authorized providers to administer such treatment as is necessary to provide behavioral health treatment, including but not limited to (check all that apply):

___Individual Therapy **___Group Therapy**

___Psychological assessment/neuropsychological testing

___Outpatient Substance Abuse Treatment

___Medication evaluation and management

___Medication Assisted Treatment (MAT)

___Other: _____

I further authorize such treatment as may be considered therapeutically necessary on the basis of findings during the course of said treatment or which may arise from presently unforeseen medical and/or psychiatric conditions.

I hereby certify that I have read and fully understand the above. The reasons why the above-named treatment is considered necessary, as well as any possible alternative modes of treatment have all been explained to me. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

_____ _____

Patient Name (Print) Patient Signature

_____ _____

Witness Signature Relationship

_____ _____

Witness Signature Relationship

PATIENT REGISTRATION FORM

Preferred Language: _____

Translator Required? **Yes:** __ **No:** __

PATIENTS NAME: _____
LAST **FIRST** **MIDDLE**

SOCIAL SECURITY: _____ **D.O.B:** ___/___/___ **SEX:** _____ **RACE:** _____ **MARITAL STATUS:** _____

MAIN PHONE: _____ **ALTERNATE PHONE:** _____ **BEST CONTACT PHONE:** _____

IS IT OKAY TO LEAVE A MESSAGE ON THIS NUMBER?

EMAIL ADDRESS: _____ **Yes** ____ **No** ____ **BEST TIME TO CALL:** _____**AM / PM**

PATIENT ADDRESS: _____/_____/_____/_____
Street Address **City** **State** **ZIP**

MAILING ADDRESS _____/_____/_____/_____
(If different) **Mailing/P.O. Box** **City** **State** **ZIP**

GUARANTOR INFORMATION: (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME: _____
LAST **FIRST** **MIDDLE INITIAL**

GUARANTOR D.O.B: _____ **GUARANTOR SOCIAL SECURITY NUMBER:** _____

RELATIONSHIP TO PATIENT: _____

EMPLOYMENT: PATIENT OR GUARANTOR *(CIRCLE ONE)*

EMPLOYERS NAME: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ **PHONE:** _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

WOULD YOU LIKE TO APPLY FOR REDUCED FEE SCALE? **__YES __ NO**

Any patient who desires reduced fees for services will be interviewed to determine eligibility. Appropriate documentation of financial information is required.

ANNUAL CONSENT FORM

☐ **CONSENT FOR TREATMENT AND INSURANCE**

I hereby give permission for the medical and /or dental staff of MCR Health to treat and prescribe medications, as they deem necessary.

This consent is freely and voluntarily entered into authorizing MCR Health to release any of the following information to my insurance company or any other paying source in order that direct payment can be made to the above institution in my behalf. I hereby agree and covenant that in consideration for the treatment of me or my Child or Spouse, I will pay the cost of this said treatment.

Signature: _____ **Date:** _____

Relationship to patient: _____

MEDICAID RELEASE OF INFORMATION (Copy of Card Must Accompany Release Form)

I certify that I am a recipient of Medicaid Program and request that payment and authorized benefits be made on my behalf. I authorize MCR Health and my insurance carrier to make available to the Florida Division of Family Services and requested information concerning medical insurance and financial records relating to my medical care. I hereby certify all insurance shall be assigned to MCR Health for services provided.

Client Signature: _____ **Date:** _____

☐ **MEDICARE LIFETIME AUTHORIZATION (Copy of Card Must Accompany Release Form)**

I request that payment of Authorized Medicare benefits be made to either me or on my behalf for the services furnished me by MCR Health. I authorize any holder of medical or other information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Client Signature: _____ **Date:** _____

ANNUAL HOUSEHOLD VETERAN STATUS FORM

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

1. Are you homeless?	**Yes:** _____	**No:** ____
2. Are you a veteran?	**Yes:** _____	**No:** ____

In the past two years or prior to retirement or disability have you or the "Head of Household":

3. Have you or the head of household worked in agricultural: planting, tilling, harvesting, or packing crops grown on the land such as fruits and vegetables?

_____**Yes (GO TO #A)** _____**No (STOP HERE)**

A. Did you or the head of household move from this area to another county or state in search of agricultural work?

_____**Yes** → Migrant Farm Worker __ **No (Go to #B)**

B. Has your family lived in this area and earned more than half their income from seasonal agriculture?

_____**Yes** → Seasonal Farm Worker

Patient/Guarantor Signature: _____ **Date:** _____

School Based Health Center Parental Consent for Services

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female Grade _____

Student Address: _____

_____

_____ _____ _____
City *State* *Zip Code*

Who is the student's regular doctor?

Name: _____

Telephone: _____

Address: _____

Allergies:

Medications: _____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____ First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, If Applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian

Home Tel: _____ Work Tel: _____

Cell: _____ Email: _____

Preferred mode of contact: phone, text or email – please circle

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have Florida Kid Care?

❑ No ❑ Yes: # _____

If your child does not have health insurance, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees. No child will be denied care due to inability to pay for services. This information will be kept strictly confidential.

Would you like a School Based Health Center representative to contact you about health insurance options/plans?

❑ No ❑ Yes What is the best time to contact you?

Does your child have coverage through your employer or any other type of health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

I understand that MCR Health will bill third parties for their services, including any applicable health insurer, or may ask students to enroll in Medicaid or another public insurance program.

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the following pages, and my signature provides consent for my child to receive services provided by the Manatee Elementary School, School Based Health Center and MCR Health, Inc.

NOTE: A **minor** is a person under the age of 18. As a rule, **Florida law** requires a **minor** who seeks medical treatment to obtain the consent of a parent or guardian. However, under certain circumstances and Florida Statutes, parental consent is not required for Emergency care (FS 743.064), Pregnancy related care (FS 743.065) Sexually Transmitted Disease care (FS 384.30), HIV/AIDS care (FS 384.23(3) & FAC R. 64D-2.004), Drug/Alcohol care (FS 397.601), Outpatient Mental Health Services (FS 394.4784). Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

School Based Health Center Parental Consent for Services

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of MCR Health in partnership with School Based Health Center and School District Manatee County. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

a. Medical care and treatment, including diagnosis and treatment of acute and chronic illness and disease, first aid for minor injuries, and dispensing and prescribing of medications.
b. Comprehensive physical examinations including those for school, sports, working papers, and new admissions.
c. Immunizations
d. Medically prescribed laboratory services
e. Health education and counseling for the prevention risk taking behaviors such as: drug, alcohol, and smoking/vaping abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infection and HIV as appropriate.
f. Vision services, which may include comprehensive eye exams including dilation, vision therapy, and the fitting and dispensing of vision correction
g. Dental services, which may include dental screening, dental cleanings, dental sealants, fluoride varnish, oral health education, and referrals
h. Provide over the counter medications and prescribe medications as they feel necessary for treatment
i. Mental health services, including screening, assessment and counseling
j. Referrals for health services which cannot be provided at this clinic.
k. Annual health questionnaire/survey.

Except I DO NOT want my child to receive the following services from the above list:

_____

If you do not want your child to receive one or more of the above services, please list here.

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be communicated and shared between MCR Health, Manatee County School District, Manatee County Health Department school clinic staff and other providers (such as your child's regular doctor or dentist), on an as needed basis for treatment of my child. This may include medical or education information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as education records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

Confidentiality between the student, parents and the health center are assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above- named child. I understand that if guardianship changes a new consent must be signed by the legal guardian.

Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. My questions about this form have been answered. **I understand that utilization of the School Based Health Center services are optional. School nursing and emergency services will still be provided as always, whether consent is given to the School Based Health Center or not.**

I understand that my consent covers only those services provided at the school-based health center. I understand that I can change my mind later, if I don't want my child to receive services at the School Based Health Center by providing a letter in writing to the school at which the student is enrolled.

I understand this consent form remains in effect during the school year in which it was signed, or until the clinic receives a written revocation from me.

My signature on page 1 of this form also gives my consent to the use and disclosure of my medical information for treatment, payment and healthcare operations by MCR Health and School Based Health Center.

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT