Southeast High School

Dear Parent or Guardian, August 3, 2023

Southeast High School is excited for the fourth year of operation of the MCR Health School Based Health Center, offering clinical and counseling services right here on campus. The existing SEHS school clinic staff will continue to manage the day to day oversight of school health and emergency services. Utilization of the MCR Health School Based Health Center is optional.

This work is a partnership of MCR Health, School District of Manatee County, and your school clinic to provide quality health care for students attending Southeast High School. This falls in line with Manatee County School District's mission of providing education and development to all students today for their success tomorrow.

Ongoing services offered through the MCR Health School Based Health Center include:

- Annual Wellness Exams
- Sick Visits
- School/Sports Physicals
- Immunizations
- Counseling Services
- Vision Screenings and Dental Services
- and More!

For your child to receive services in the School Based Health Center, a parent or legal guardian must read, complete, and sign the application package/consent forms that are attached. Even if your child already has a primary care doctor, they can still benefit from our health services should a problem arise in school. Most private insurance, as well as Medicaid, is accepted. For students with no insurance, sliding scale fees are available for those who qualify.

For more information about the School Based Health Center, call (941) 741-3366 ext. 36078. To schedule an appointment, call (941) 245-0056. The School Based Health Center is located on campus in Portables 422 and 423 and will be open Monday-Friday, 7:00am-4:00pm when school is in session.

The goal of this program is to improve academic outcome by improving the overall health of our students. At Southeast High School, we recognize healthy students are the future of tomorrow.

Sincerely,

Ginger Collins
Principal

"All student information will be protected by the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers."

Detach and Keep This Page for Your Records

1200 37th Avenue East, Bradenton, Florida 34208 phn (941)741-3366 fax (941)209-7327

SEHS 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.

Why are we partnering with MCR Health?
For 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 are one of the largest, most diversified Federally Qualified Health Centers in the southeastern U.S. **MCR Health accepts most private insurance, Medicaid, and has a sliding fee scale for those that are eligible and don't have insurance.**

How does the MCR Health School Based Health Center work?

- A parent/guardian must complete the consent/application forms, which are available at the front desk, guidance desk, school clinic, portable #423, or on the SEHS website. Your student can bring the completed paperwork to the main office, ATTN: School Based Health Center, or to Portable 423.
- **Appointments at the MCR Health School Based Health Center can be made by calling 941-245-0056 once there is a consent on file.**
- If your child is feeling sick at school, they will continue to go to the school clinic and the school clinic staff will contact a parent/guardian regarding use of the School Based Health Center. If the student has a consent on file, they can be referred directly to the School Based Health Center(Portable #422). If the student does not have a consent on file for the School Based Health Center, the school clinic staff will follow their current procedure.
- **The School Based Health Center does not take the place of your child's regular doctor** and completing the consent packet does not mean you are changing your child's doctor. If your child is already a patient of MCR Health, you will still have to sign the School Based Health Center consent packet to utilize the services.

For more information about the School Based Health Center, call (941) 741-3366 ext. 36078.
The School Based Health Center is located on campus in Portables 422 and 423 and will be open Monday-Friday, 7:00am-4:00pm when school is in session.

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Southeast High School
School Based Health Center Parental Consent for Services

Current Southeast High School Student: ❑ YES ❑ NO

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

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

Student's Social Security Number: _____

Sex: ❑ Male ❑ Female Grade _____

Student Address including city, state and zip code:

_____

_____

Who is the student's regular doctor?

Name:_____

Telephone:_____

Address: _____

Current Medications: _____

Known Allergies: _____

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

Is your child currently a patient of MCR Health?

❑ No ❑ Yes

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.

Does your child have insurance 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 Southeast High 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), Family Planning and Contraceptive care (FS 381.0051), 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 the other side 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

Southeast High School
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 Southeast High School, School Based Health Center, 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 fortreatment
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.

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 SEHS 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 Southeast High School. I understand that I can change my mind later, if I don't want my child to receive services at SEHS School Based Health Center by providing a letter in writing to: SEHS School Based Health Center, 1200 37th Ave East, Bradenton, FL 34208.

I understand this consent form remains in effect during the years my child attends SEHS, School District Manatee County schools, or until the clinic receives a written revocation from me.

My signature on the other side 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 SEHS School Based Health Center.

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

PATIENT REGISTRATION FORM

PREFERRED LANGUAGE_____

TRANSLATOR REQUIRED? YES____ NO____

PATIENT INFORMATION:

PATIENT'S NAME_____
LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY NUMBER_____ D.O.B._____ SEX_____ RACE_____

MARITAL STATUS_____ MAIN PHONE_____ ALTERNATE PHONE _____

BEST CONTACT PHONE NUMBER _____ EMAIL ADDRESS _____

IS IT OK TO LEAVE A MESSAGE ON THIS NUMBER? YES___ NO___ BEST TIME TO CALL YOU _____ AM PM

PATIENT'S ADDRESS_____
STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS, IF DIFFERENT _____
MAILING / PO 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)

EMPLOYER'S NAME _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

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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 feel necessary on me or my ☐ Child ☐ Spouse. I, as parent, legal guardian or responsible adult, must accompany my child to MCR Health and stay with them throughout the entire examination.

My spouse has either given me permission to request treatment from MCR Health on his/her behalf or has been granted by a court of competent jurisdiction and I will submit the authority to MCR Health.

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 ☐ 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 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 _____ No → Stop here
↓ (Go to # A)

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: _____