MADIGAN SCHOOL-BASED HEALTH SYSTEM CONSENT FOR SERVICES
RIVER RIDGE HIGH SCHOOL 2019-2020

The Madigan School-Based Health System is a joint effort of local School Districts and Madigan Army Medical Center (MAMC) designed to promote the physical, behavioral and emotional well-being of military dependent adolescent students at their schools. It is a military and community collaboration for improving the quality of life for our nation's warriors and their families.

WHAT IS A SCHOOL-BASED HEALTH CENTER? It is a comprehensive, primary care center located in a school. The staff includes a physician or a family nurse practitioner with licensed practical nurses or registered nurses, and administrative staff.

WHAT DO SCHOOL-BASED HEALTH CENTERS DO? School-Based Health Centers provide Immunizations, School Physical Exams, Referral for Specialty Care, Nutrition and Weight Counseling, Behavioral Health Screening and Counseling, Diagnosis and Treatment of Minor Illnesses/Injuries, Pregnancy prevention education and contraceptive management, Reproductive Health Management such as Sexually Transmitted Infection Screening and Treatment, Treatment of Asthma, Anemia, Acne, Anxiety, Depression, ADHD, Diabetes, and Other Health Problems. Other complicated concerns may be referred for appropriate services at MAMC, or in emergency situations, to the Emergency Department co-located at MAMC.

HOW CAN A STUDENT USE THE HEALTH CENTER? Generally a student **must** have a consent form signed by his/her parent or guardian to receive health center services. If the student is 18 years old or older or emancipated, he/she can sign his/her own consent form. The consent form is valid for the 2019-2020 school year and will be maintained at the school clinic for availability by the medical provider to ensure student eligibility for medical services. Parents will be notified by telephone after each clinical encounter to provide feedback regarding their child's current condition. Parents have the option to be present during the clinical appointment at the schools. Parents or guardians may withdraw the consent, provided by this authorization, at any time in writing.

HOW CAN APPOINTMENTS BE MADE? Appointments can be made by calling **TRICARE at (800) 404-4506** and specify the appointment is for a School-Based Health Center. Appointments can also be made by calling the **School-Based Health Center at (253) 968-4804.** The Madigan School-Based Health System team will provide health services at the following location from **8AM - 10:30AM** in the North Thurston School District:

River Ridge High School every other Friday Morning

**We also service the Steilacoom School District (Steilacoom HS and Pioneer MS), Bethel School District (Bethel HS and Bethel MS), Clover Park School District (Harrison Prep, Lakes HS, Mann MS and Woodbrook MS), and Puyallup School District (Roger HS).

CONFIDENTIALITY: The Madigan School-Based Health System adheres to all current state laws regarding confidentiality of health services in general and specifically as they relate to services to minors. Parental consent will not be required when state or federal law gives an eligible military student beneficiary the right to consent for services without such parental consent. The Notice of Privacy outlines how Madigan may use and disclose your teen 's protected health information at MAMC. All student information and documents maintained by the Madigan School-Based Health System will be handled by health center personnel only.

The participating School Districts and MAMC are committed to maintaining a partnership that ensures easy access to health care for all eligible military beneficiaries. By operating a health center at schools, MAMC offer beneficiaries a unique opportunity to promote a safe and healthy school environment for all students. Madigan staff will cooperate and communicate with the school staff whenever student behavior or health may result in risk or harm to the student or others within the educational setting. The Madigan staff will follow policies and procedures developed by MAMC as well as district board policies and procedures. Completing and signing the attached form authorizes participating schools to release and receive information as identified in the MAMC Privacy Notice.

I have read the above and understand the above statements. This consent expires June 30, 2020.

Parent/Guardian Signature _____ **Date** _____

Student's Name: _____

MADIGAN'S SCHOOL-BASED HEALTH CENTER

PARENT PERMISSION FORM

Please complete all information on the front and back of this permission form. For your child to receive services from the School-Based Health Center, you must sign and date the form. If a student is 18 years old or older, he/she can sign his/her own permission form.

Student's Name: _____ Male / Female Grade: _____

Student's DoD ID Number: _____ Birth Date: _____

Address: _____ City: _____ Zip Code: _____

Mother_____ Work Phone _____ Cell Phone_____

Email _____

Father_____ Work Phone _____ Cell Phone_____

Email _____

Guardian _____ Work Phone _____ Cell Phone_____

Email _____

Emergency Contact: We will utilize the schools emergency contact protocol.

Does your child have a history of any of the following? (If yes, please explain):

1. Y N Allergy to food or medicine _____

2. Y N Taking medicine regularly _____

_____

3. Y N Chronic health problem such as: asthma, diabetes, obesity, behavioral health etc.

_____

I have read the information supplied to me regarding the services of the School-Based Health Center and give permission for the above named student to use the services provided by the School-Based Health Center for as long as she/he is enrolled in the North Thurston School District.

I certify that the student is enrolled in Defense Eligibility Enrollment Reporting System (DEERS).

As the parent/guardian of the student identified above, I understand that I may revoke the permission at any time for any reason. I also acknowledge receipt of the School-Based Health Center Informational Sheet.

_____ _____

Parent/Guardian Signature **Date**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
20190831 to 20200630	[X] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Madigan Army Medical Center - School Health Clinics TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
River Ridge High School Nursing/Health/Sports Team Professionals	350 River Ridge SE, Lacey, WA 98513
c. TELEPHONE *(Include Area Code)* (360) 412-4820	d. FAX *(Include Area Code)* (360) 412-4839

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
[ ] PERSONAL USE [X] CONTINUED MEDICAL CARE [X] SCHOOL [ ] OTHER *(Specify)*
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
School Sports Participation Form Clearance, Immunization Records, other pertinent health information as applicable.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	[X] DATE *(YYYYMMDD)* 20200630 [ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

PARENTS – Please keep this copy for your records

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