ST. HELENA
PARISH SCHOOL DISTRICT

Board of Education
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District Vision: To create an equitable, productive school culture that increases student achievement, develops educator effectiveness, and builds public confidence.

St. Helena Parish Takes Necessary Preventive Measures to REDUCE THE SPREAD OF COVID-19 – SHATA/SHCCA

The St. Helena Parish School District considers the health and well-being of our students and staff to be of the upmost importance. Through our partnership with Southeast Community Health Systems, we have established policies and protocols to mitigate COVID-19 exposure while our employees and students are on campus. Our measures are working, and we have not had to shut down our schools.

However, it is difficult to maintain our safe school environment when a lot of our students are exposed to the virus while at their homes. Unfortunately, we have cases where families, despite the recommendations from the Center for Disease Control (CDC), attend large gatherings or other community events that can expose them to COVID-19. It is with that in mind the following provisions have been taken, with no exception:

1. All students are required to submit the **Southeast Community Health Systems Consent Form** to return to school. No student will be allowed on any campus without the signed form. Please visit our district website to access the online form.
2. All students will be **tested for COVID-19 this Monday, November 16th**. If a parent decides not to have their child tested, that student must quarantine for 14 days.
3. All schools will be **closed Friday, November 13th for deep cleaning**. No virtual classes will be held on that day either. Schools will reopen Monday, November 16th.
4. Students must **always wear their face masks on the bus and at school**. While all students are aware of this requirement, some fail to comply. Future non-compliance **will result in out of school suspension and a 14-day quarantine.**
5. Parents/guardians must inform the school immediately if their child is suspected of having COVID-19 or experience COVID-like symptoms. That student and any children living in the same household must remain home. In addition, all students in the home must be tested and provide the school with their negative test results before returning to school.

COVID-19 is real. Our nation is experiencing a second wave of this virus that is threatening the lives of all citizens. We are all going to have to do our part if we want our schools to remain open. The health and safety of our employees and students will be protected. As such, these strict provisions are necessary and will not be compromised.

Kelli Joseph
Superintendent

Dr. Kelli Joseph, Superintendent
354 Sitman Street, Greensburg, LA 70441
P.O. Box 540 | 225-222-4349

SOUTHEAST COMMUNITY Health Systems

Southeast Community Health Systems School-Based Health Centers
____Early Learning Center ____Arts & Technology ____College & Career

COVID-19 Screening Consent Form

Section 1: Information about Child to Receive COVID-19 Screening (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** month_____ day_____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** M / F
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
STUDENT'S DOCTOR'S NAME (Last, First)	**Address**		**City**	**Zip**

SCHOOL NAME	**HOMEROOM TEACHER'S NAME**	**GRADE**

Section 2: Screening for COVID-19

The following questions will help us to know if your child should be screened for COVID-19. If you answer "YES" to one or more of the following four questions, your child, should be screened for COVID-19 and may be quarantined and sent home for 14 days until the results of confirmed, whichever is shortest. You will be contacted prior to screening.

Please mark YES or NO for each question.

	YES	**NO**
• Does your child have a sore throat, cough, chills, body aches, shortness of breath, loss of smell, loss of taste, nausea, vomiting, diarrhea, fever at or greater than 100 degrees Fahrenheit?	☐	☐
• Have you, your child or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches, shortness of breath, loss of smell, loss of taste, nausea, vomiting, diarrhea, fever at or greater than 100 degrees Fahrenheit?	☐	☐
• Have you or anyone in your household traveled in the U.S. in the past 21 days or have you or anyone in your household traveled on a cruise ship in the last 21 days?	☐	☐
• To the best of your knowledge have you or your child been in close proximity to any individual who tested positive for COVID-19?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S COVID-19 SCREENING:

I have read or had explained to me the process for COVID-19 screening and understand the risks and benefits.

____ **I GIVE CONSENT** to Southeast Community Health Systems and its staff for my child named at the top of this form to be screened for COVID-19. (If this consent form is not signed, then your child will not be screened.)

____ **I DO NOT GIVE CONSENT** to Southeast Community Health Systems and its staff for my child named at the top of this form to be screened for COVID-19.

Signature of Parent/Legal Guardian _____

Date: month_____day_____year_____

SOUTHEAST COMMUNITY Health Systems
Health, Vitality & Wellness

Email completed registration form to telemed@shchc.org.

Dear Parent:

As you know, Southeast Community Health Systems has been providing counseling and medical services to St. Helena students for over 20 years! This letter is a simple reminder of the benefits to completing the attached consent form.

Medical services:

- Primary and preventive health care
- Comprehensive history and physical examinations
- Immunizations
- Health screenings
- Laboratory/diagnostic testing
- Acute care for minor illness and injury including medications, if indicated
- Management of chronic diseases
- Health education and prevention programs
- Tele-Medicine

Behavioral health services:

- Individual, group, and family therapy
- IEP meetings, and support/advocacy for the student where needed
- Anger management
- Conduct problems
- ADHD
- Anxiety/Depression
- Grief
- General issues surrounding transitioning to a new grade, school, or family situation
- Tele-Behavioral Health
- Psychiatric Assessment
- Medication Management

These services are provided to your student by highly trained and licensed medical and behavioral health staff. With your consent, our providers will be able to share basic information with St. Helena Parish School Board and your child's teacher as needed to ensure your child is receiving the academic resources needed for their success. We are your child's biggest advocate at their school. Please take the time to complete the packet. If you have any questions, concerns, or would like to discuss your child's specific needs, please contact us at 225.306.2001. Thank you!

Sincerely,

Benjamin Larisey, LCSW, MHA
Coordinator of Behavioral Health and School-Based Services
Southeast Community Health Systems

Office use only.

Student's Name: _____ 2nd Identifier _____

The following information is a copy of the general consent, patient rights, patient responsibilities, advanced directive acknowledgement, and the acknowledgement of receipt of privacy practice. Your signature is required and is requested at the end of the following consent packet. ***Please keep the next two pages for your records.***

GENERAL CONSENT FOR TREATMENT

1. I hereby authorize and consent to all necessary medical procedures needed for diagnosis and treatment for me and/or my dependents by Southeast Community Health Systems (SCHS).
2. I understand that no guarantee or assurance has been made as to the results that may be obtained.
3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by SCHS.
4. I give permission to release to my insurance company medical information necessary in the filing of lawful claims by SCHS' staff for services rendered by SCHS to me or my dependents.
5. I hereby authorize payment directly to SCHS of benefits relative to pending claims and/or Major Medical benefits otherwise payable to me, not to exceed SCHS' regular charges for this service.
6. I certify that the information that I have provided in applying for payments under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries, carriers, or any other insurer, any information needed for this or any related Medicare/Medicaid Claims. I request benefits be paid on my behalf.
7. I agree that a photocopy of this form is as valid as the original.
8. I agree and understand that the medical records are the property of SCHS; however, I can request a copy for a nominal fee at any time.
9. I understand that general information regarding my child's diagnosis and treatment can be shared with IEP committee members, his/her teacher, and other staff connected with the St. Helena School Board as needed to assist in coordinating appropriate care of your child.
10. I understand that I can provide written objection of what information is shared with the school staff.
11. I certify that the information provided is true to the best of my knowledge.

PATIENT RIGHTS

1. Effective communication, to know what is going on. If you do not know, ask questions until you are sure you understand.
2. Be interviewed and counseled about personal matters in a private office.
3. Know why certain information is wanted, needed, or asked for.
4. Consent in advance to any visits made to your home
5. Expect that your medical records will not be given to anyone without your permission
6. Expect that your case will only be discussed with those involved in your care.
7. Know what the doctor has found as a result of examining you, and any anticipated outcomes.
8. Know about any medication or treatment that the doctor believes you should have
9. Accept or refuse any medication or treatment
10. Be treated with respect and dignity as an individual person, having your cultural, spiritual, psychosocial values and beliefs respected
11. Make known immediately to to any member of administration (Front Desk, Supervisor, Management, etc.) any problems encountered during a visit to the Health Center. If a member of the organization cannot

Office use only.

Student's Name: _____ 2nd Identifier _____

address your concerns, you are encouraged to contact the Southeast Community Health Centers **Corporate Compliance Officer** at **(855) 368-6272** or email Compliance@shchc.org to report your concern.

12. Be free from abuse, neglect and exploitation
13. Expect pain management considerations
14. Patients are encouraged to choose a doctor of record as their primary care provider to optimize continuity of care.
15. I have read and understand my rights and responsibilities as a patient of Southeast Community Health Systems and understand that if the quality of my care is compromised and if SCHS management staff cannot address it in a timely fashion, I have the option to report the healthcare compromise to the Joint Commission on Accreditation of HealthCare Organizations at (800) 994-6610, or complaint@iointcommission.org

PATIENT RESPONSIBILITY

1. I acknowledge that I am fully responsible for any and all expenses incurred at Southeast Community Health Systems for myself and/or dependents/family members.
2. I understand that all payments are due at the time of service.
3. I understand that all payments must be made towards any outstanding balance in addition to the payment for the current date of service rendered.

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

I understand that Southeast Community Health Systems does not honor Advanced Directives. In the event of a medical emergency during the clinic visit, first aid measures will be provided, 911 called and hospital transfer initiated.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I wish to place the following restrictions on disclosure of my health information (Please list below or write N/A if no restrictions)

INSURANCE ASSIGNMENT: I assign directly to Southeast Community Health Systems (SCHS) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize SCHS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and for a copy for this statement and my signature to be kept on file and used in place of this original.

Office use only. **Student's Name: _____ 2nd Identifier _____**

Email completed registration form to telemed@shchc.org.

ST. HELENA PARISH SCHOOLS
LOUISIANA ENROLLMENT/CONSENT FORM
FOR SCHOOL-BASED HEALTH CENTERS
ST. HELENA ARTS AND TECHNOLOGY / ST. HELENA COLLEGE AND CAREER ACADEMY
2020/2021 SCHOOL YEAR

Student's Name: Last	First	Middle Initial		ID# (Office use only.)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	
Student's Gender Identity (Select One): ◯ Male ◯ Female ◯ Transgendered ◯ Refuse to Answer · Other (explain):				
Student's Sexual Orientation (Select One): ◯ Straight ◯ Lesbian ◯ Gay ◯ Bisexual · ◯ Refuse to Answer · Other (explain):				
Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race				
Student's Social Security Number:	School:		Student's Grade:	
Preferred Language:	Parent/Guardian Email:		Student's Cell Phone:	
Name of Mother (include maiden name) or Legal Guardian:	Home Phone:	Work Phone:	Cell Phone:	Employer:
Name of Father or Legal Guardian:	Home Phone:	Work Phone:	Cell Phone:	Employer:
Emergency Contact:		Relationship:		Phone:
Emergency Contact:		Relationship:		Phone:
Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑				Phone:
Name of Student's Dentist: Please check if student does not have a Dentist ❑				Phone:
Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:			

Office use only.

Student's Name: _____ 2nd Identifier _____

Please check the type of health insurance your child has: **Please send a copy of insurance card (front and back) to the School Based Health Center or email with this form.**	❑ Medicaid/Healthy Louisiana #: _____ (check one below) ❑ Aetna Better Health ❑ Amerigroup Real Solutions ❑ AmeriHealth Caritas LA ❑ LA Healthcare Connections ❑ United HealthCare Community Plan ❑ Medicaid (dental)#: _____ ❑ No insurance ❑ Private/Other Insurance Co. Name:_____ Co. Address:_____ Phone #:_____ Policy #:_____ Group#:_____ Effective Date:_____ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder Social Security #:_____ Does your insurance pay for prescriptions? ❒ No ❒ Yes

Does your child have any known allergies to food, medications, insects, etc? Please list.

If your child does not have health insurance, would you like information on no cost health insurance?
❑ Yes ❑ No

List of current medications student is on with dosage (how much) and how often:

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the Office of Public Health ("OPH"), Adolescent School Health Program provides oversight to the SBHC and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Confidentiality: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). However, basic information can be shared with the St. Helena School Board, IEP/504 committee, and your child's teacher as needed and for the purposes of ensuring his/her academic and social needs are appropriately met. I consent to the exchange of relevant health information between Southeast Community Health Systems and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Southeast Community Health Systems has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 225.306.2097 My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

Office use only.

Student's Name: _____ 2nd Identifier _____

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product**.**

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

Southeast Community Health Systems has an MOU with St. Helena Parish School Board to offer medical, dental and behavioral health services through Southeast Community Health Systems School Based Health Center to students and staff at the St. Helena College and Career Academy, St. Helena Arts and Technology Academy, and St. Helen Early Learning Center. SCHS and St. Helena Parish School Board works collaboratively in meeting the whole need of the population served.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available) ♦Provider involvement in IEP and 504 committees, and the sharing of basic information to the student's teachers to ensure academic and social resources are provided to the student.

Office use only.

Student's Name: _____ 2nd Identifier _____

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that St. Helena Arts and Technology or St. Helena College and Career Academy or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to St. Helena Arts and Technology or St. Helena College and Career Academy.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in (insert name of school, school system or sponsoring agency) unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

We also understand that the school-based health center is operated by Southeast Community Health Systems and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student (optional) Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

FAMILY INCOME INFORMATION

We request income on all patients for governmental reporting purposes. If eligible for the Sliding Feed Scale, please complete separate Sliding Fee Application.

Income Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other:

Gross Household Income: $_____ Number of Individuals Income Supports: $_____

Office use only.

Student's Name: _____ 2nd Identifier _____

***This consent may be withdrawn or modified at any time with written request of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.**

I acknowledge that I have been provided information regarding:

- ☒ **General Consent for Treatment**
- ☒ **Patient Rights**
- ☒ **Patient Responsibilities**
- ☒ **Advanced Directive Acknowledgement**
- ☒ **Acknowledgement of Receipt of Notice of Privacy Practice**
- ☒ **Insurance Assignment**

Signature of Patient (or Guardian): _____ Date: _____

Relationship to patient if not signed by patient: _____

Office use only.

Student's Name: _____ 2nd Identifier _____

Consent for Tele-Health Services

Telemedicine allows patients access to medical care using audio-video interface such as videoconferencing. For the purposes of this consent form, all treatment is referring to medical and behavioral health care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. A licensed health care professional who can adequately and accurately assist with access to medical records, orders, and emergency patient care will always be in the examination room with the patient that the patient is receiving telemedicine services.

Expected Benefits:

- Continuity of care with same healthcare provider.
- Improved access to medical care.
- Obtaining expertise of a distant specialist.

Possible Risks:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consultant.
- Delays in evaluation and treatment could occur due to equipment failure.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. To prevent this from occurring, the software that is being used is compliant with HIPAA standards and employs a firewall, router, and VPN-based access controls to secure the private-service networks and backend servers.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction, and may receive copies of this information upon request
4. I understand that alternative methods of medical care may be available to me and that I may request to choose an alternative method of care (pending availability of other healthcare providers).
5. I understand that it is my duty to the extent that I am able to inform my healthcare provider of any change in my mental and/or physical health.
6. I understand that I may expect the anticipated benefits from medical care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine:
I have read and understand the information provided above regarding telemedicine, have discussed it with my healthcare provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine to provide medical and behavioral health care.

Patient's Name: _____ Date of Birth: _____

Guardian Signature: _____ Date: _____ Email: _____