HEALTH PROMOTION
DISEASE PREVENTION
FORT PECK TRIBES

Fort Peck Tribes HPDP Wellness Program
417 13th Avenue East, P.O Box 1027
Poplar, MT 59255
North Side WP School Based Health Clinic (406) 653-1653 EXT.333
South Side WP School Based Health Clinic (406) 653-1480 EXT.203

Dear Parent or Guardian,

Enclosed is a consent or refusal form to our School Based Health Clinics. This consent is required to be completed and signed by a parent or legal guardian in order for your child to receive any services provided by HPDP. The consent form has changed and will no longer need to be filled out every year. After completing the enclosed consent, we will be able to see your child until the age of 18, unless you notify us otherwise.

HPDP has several benefits such as preventive dental procedures (teeth cleanings, sealants, fluoride treatments, and oral hygiene education), sports physicals, immunizations, acute care visits, nutrition and counseling. Our professionals include School Nurses, Nurse Practitioners, Mental Health Providers, and Dental Hygienists. All of these services/providers are accessible at no charge to your child and are available regardless of insurance coverage, race, or ethnicity. You may decline some or all of these services by noting your specific requests on the consent form. Please fill out whether or not you would like to participate in our program. Your cooperation in this matter is extremely helpful to us and we look forward to seeing your child in the upcoming school year.

Thank you for your time and consideration and feel free to contact us with any questions or concerns.

Sincerely,

HPDP School Based Health Clinics

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Keep Our Kids Healthy So They Can Stay In School

Our goal is to provide high quality Nutritional, Physical, Mental and Dental health services, Case Management services and health education to students. If your child comes to the School Based Health Clinic (SBHC) to see a Provider, **we will contact you before any care is provided**. We will also contact you after your child has received services to inform you of the outcome of the visit. We would love to have your child be a part of the program! Please fill out the consent attached and send it back to school with your child.

If you chose **NOT** to enroll your child within the School Based Health Clinics, please fill out the information below and send it back to school with your child. It is important that we receive the consent or the information below so we do not resend consents to you. **If you have questions or concerns, please feel free to contact us.**

☑ I choose to decline the School Based Health Clinics services listed above for my child:

Student:_____ DOB:_____ Teacher:_____ School:_____

Parent Signature:_____ Date:_____

HPDP Tribal Wellness Program School Based Health Clinics

(406) 768-3052 Admin office (949) 863-5301 Fax
(406) 768-3384 Direct line Poplar School-clinic
(406) 786-3202 Direct line Brockton School-clinic
(406) 695-2117 Direct line Frazer School-clinic

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Home Phone: _____ Social Security # _____

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

What type of insurance does student have?

☐ None ☐ IHS ☐ Medicaid #_____ ☐ Medicare# _____

☐ Private insurance _____ Subscriber's Name _____ Subscriber's DOB _____
Plan #_____ Policy #_____

☐ **I am unable to pay for any medical services not covered by insurance reimbursement.**

Where does student usually go for medical care? _____ Dental care? _____

As part of the healthcare reform law, the Federal government requires us to obtain primary race and language information to measure and improve the delivery of healthcare services. Please answer the following questions for student only:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred language: _____

Race(s)- Check all that apply:

☐ American Indian/Native Alaskan ☐ African or African American ☐ Asian or Asian American

☐ Caucasian or European American ☐ Native Hawaiian or Other Pacific Islander ☐ Other

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship of Guardian to Patient: ☐ Parent ☐ Grandparent ☐ Other: _____

Please complete ***and check*** preferred method of communication:

☐ Home Phone _____ ☐ Work Phone _____

☐ Cell Phone: _____ ☐ Email _____

Parent/Guardian #2

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship of Guardian to Patient: ☐ Parent ☐ Grandparent ☐ Other: _____

Please complete ***and check*** preferred method of communication:

☐ Home Phone _____ ☐ Work Phone _____

☐ Cell Phone: _____ ☐ Email _____

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

MEDICAL/DENTAL/MENTAL HEALTH CONSENT: The HPDP School Based Health Centers (SBHC) must have a signed consent from a parent or legal guardian before providing services to youth, except where federal and/or state laws allow youth to access such treatment without parent/guardian consent.

I hereby request and authorize treatment for any and all health care services available from and deemed necessary by the providers and volunteers of the HPDP School Based Health Clinics. These services may include, but are not limited to, well-child care, evaluation, treatment of acute illness and injuries, immunizations, blood studies, dental screening and treatment (including varnish, sealants, cleanings), wellness counseling and mental health evaluations and counseling. Consent is also given for referral of care and, if needed, emergency transportation, to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the SBHC staff. **Consent for service is authorized for any SBHC run by HPDP to provide services until your child reaches the age of 18 years old.** I may choose to limit or withdraw the consent for any or all services by notifying HPDP in writing.

I understand that I will be consulted and notified by phone or in person prior to any immunizations, laboratory /radiology tests or dispensation of medications, ***unless*** the condition is life threatening.

IMMUNIZATION REGISTRY: I authorize HPDP to enter my or my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

CONFIDENTIAL CARE: I am aware that the information about my child is confidential and will not be shared with others, including school personnel, except in the following circumstances: 1. Permission to share information is given by a signed release of information. 2. The student shows risk of suicidal behavior. 3. The student plans to do serious bodily harm to another person. 4. The student has a life-threatening problem and is under 18 years old. 5. There is a reason to suspect abuse or neglect. 6. Certain communicable diseases must be reported to the State Health Department. *A student's consent is legally required to release information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted disease, alcohol and drug use or mental health counseling. The SBHC encourages youth to involve parents/guardians in health care decisions whenever possible.*

ASSIGNMENT OF INSURANCE BENEFITS; I authorize HPDP to request on my behalf, and to collect directly, all public and private insurance coverage benefits (including Medicare, if applicable) due for products and services supplied by HPDP providers in the SBHC. In the event insurance benefits are paid directly to me, I will endorse to HPDP all checks for such payments.

MEDICARE CERTIFICATION (when applicable): I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize HPDP to disclose any health information to my insurers (including the Center for Medicare and Medicaid Services or its representatives, if applicable) necessary to facilitate the processing of claims or audit of payments relative to the services provided to me or my child by HPDP.

By signing below, I am acknowledging full understand of the above notice and hereby indemnify and hold harmless the providers, medical office and other persons who act in reliance upon this authorization.

Parent/Guardian Signature _____ Relationship _____ Date _____

HIPAA/NOTICE OF PRIVACY PRACTICES: We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the HPDP Privacy Officer. The Fort Peck Tribes **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. The Fort Peck Tribes **Notice of Privacy Practices** is posted on our website at *http://www.fortpecktribes.org/hpdp/staff.html* and is posted in each SBHC.

By my signature below I also acknowledge I have been offered a copy of the Fort Peck Tribes **Notice of Privacy Practices.**

Parent/Guardian Signature _____ Date _____

HEALTH PROMOTION
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FORT PECK TRIBES

HPDP Tribal Wellness Program School Based Health Clinics

Patient Health History Form

Student's Name _____ Today's Date _____
Student's Teacher _____ Grade _____

☐ **NO CHANGE IN INFORMATION**

Pregnancy & Birth History

While pregnant, did mother:
Have any complications?_____Yes No
Use alcohol, drugs or smoke?_____Yes No
Take any medications?_____Yes No
Length of pregnancy:_____Weeks
Type of delivery:_____
Birth weight:_____ lbs._____oz.
Newborn hearing screen passed?_____Yes No
Delivered at:_____
Name of Hospital

Child's Current Health

Is your child taking prescription or over the counter medications (i.e. vitamins)? _____Yes No
Name of medications:_____
_____
Any allergies to medications?_____Yes No
Please list:_____
_____
Any dental problems?_____Yes No
Any allergies to latex or anesthesia: Yes No

Family Health History

Parental Height: Mother:_____ Father:_____
Have and close family members **(parents, grandparents and siblings)** had any of the following **(State whom)**:

Hearing Problems:_____
Vision Problems:_____
Asthma:_____
Hay Fever or Allergies:_____
Heart Disease Prior to age 50:_____
High Blood Pressure:_____
Elevated Cholesterol:_____
Diabetes:_____
Thyroid Disease:_____
Kidney Disease:_____
Epilepsy (seizures):_____
Cancer (type):_____
Liver Disease:_____
Bleeding Disorder/Blood Clots:_____
Smokers:_____
Alcohol or Drug Abuse_____
Depression or Mental Illness:_____
ADHD:_____
Learning Disability:_____
Scoliosis:_____
Reactions to Anesthesia:_____
Other:_____

Child's Health History

Hospitalizations:_____Yes No
Illness:_____Date:_____
Surgeries:_____Yes No
Procedures:_____Date:_____
Injuries/Fractures:_____Yes No
Hearing Problems:_____Yes No
Vision Problems_____Yes No
Ear/Nose/Throat Problems_____Yes No
Asthma/Breathing Problems:_____Yes No
Hay Fever or Allergies:_____Yes No
Diabetes/Thyroid Problems:_____Yes No
Kidney Problems:_____Yes No
Heart Murmur/Conditions:_____Yes No
Stomach Problems:_____Yes No
Migraines or Headaches_____Yes No
Anemia/Low Iron:_____Yes No
Learning disability/ADHD:_____Yes No
Head Injury or Concussion:_____Yes No
History of High Fevers:_____Yes No

HEALTH PROMOTION
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Fort Peck Tribes HPDP Wellness Program
Frazer School –Based Health Clinic (406) 695-2117
Poplar School – Based Health Clinic (406) 768 – 3384
Brockton School – Based Health Clinic (406) 786 – 3202

Authorization for the Administration of Over-The-Counter Medication by School Based Health Center Personnel

To help keep students in school, the HPDP school-based health centers stock a limited number of over the counter medications and medicated creams and ointments that may be administered to students enrolled in the program. Written consent must be provided from the parent/guardian, permitting HPDP personnel to administer medications to the student during the school year. Except in the event of an emergency, the student's parent or guardian will be called for verbal consent prior to the administration of any of these medications in order to avoid duplication of medication.

All medications will be routinely monitored for expiration dates and stored in the original bottle with unaltered label. Medications requiring refrigeration will be properly stored and transported. Medication will be administered in accordance with standing orders for the administration of these medications. Medications are administered by the HPDP Registered Nurses, Nurse Practitioners or Physicians trained in the methods of administration of medications.

Prescription medications require a separate authorization of medication form to be completed by a student's parent/guardian before these medications will be administered.

AUTHORIZATION BY PARENT/GUARDIAN

I hereby authorize the administration of the medications listed below by authorized HPDP personnel:

Can your child have the following medications in the School Based Health Clinic if necessary?

☐Yes	☐No	Acetaminophen (Tylenol) for pain or fever
☐Yes	☐No	Antibiotic ointment for abrasions, scratches, cuts, and burns
☐Yes	☐No	Benadryl for allergies or allergic reaction
☐Yes	☐No	Cetirizine (Zyrtec) for allergies
☐Yes	☐No	Cough drops for cough or sore throat
☐Yes	☐No	Cough medication (dextromethorphan) for cough
☐Yes	☐No	Honey for cough
☐Yes	☐No	Hydrocortisone cream or ointment for hives, insect bite, poison ivy or stings
☐Yes	☐No	Ibuprofen for mild headaches, joint or tooth pain, menstrual cramps
☐Yes	☐No	Lotion for dry skin
☐Yes	☐No	Lip balm for chapped lips
☐Yes	☐No	Tums for upset stomach or heart burn

Student Name _____ DOB _____

Printed Name _____ Relationship to student _____

Signature _____ Date _____

FORT PECK TRIBES HEALTH PROMOTION DISEASE PREVENTION PROGRAM
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.

The Health Promotion Disease Prevention Program respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

How we may use and disclose your protected health information:

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories. Examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you. However, most uses or disclosures of any psychotherapy notes will require your authorization.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.
- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs
- We will not contact you to raise funds.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- **Required by law**: We must make any disclosure required by state, federal, or local law.
- **Business Associates**: We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital
- **Public** health and safety purposes: As permitted or required by law, we may disclose protected health information: to prevent or reduce a serious, immediate threat to the health or safety of a person or the public; to public health or legal authorities; to protect public health and safety; to prevent and control disease, injury or disability; to report vital statistics such as births and deaths; and to report suspected abuse or neglect to public authorities.
- **Research**: We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners and funeral directors**: We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations**: Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness**: State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions**: If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement**: We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government** health and safety oversight activities: We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief**: We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State**: We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes**: We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security**: We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information**: We may use your protected health information by removing any information that could be used to identify you.

Your health information rights:
The health and billing records we create and store are the property of HP/DP. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about a service or treatment for which you paid directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months.
- You have the right to restrict certain disclosures of PHI to a health plan when you (or any person other than the health plan) pays for treatment at issue out of pocket in full.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

We are required to:
- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.
- Notify you following any breach of the security of your protected health information.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting the HPDP office in Poplar to pick one up.

To ask for help or complain:
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

The HPDP Privacy Officer
417 13th Avenue East
Poplar, Montana 59255
(406) 768-3383

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the HP/DP Privacy Officer at the above address You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

Web site: We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: http://www.fortpecktribes.org/hpdp/staff.html