



Dear Parents/Guardians:

Did you know that your son or daughter can get HEALTH CARE at the West Seattle Teen Health Center? The Teen Health Center is located at West Seattle High School and is operated by Neighborcare Health, a Seattle Community Health Center network of 17 medical, dental and school-based clinics, serving more than 45,000 patients each year. The Teen Health Center also receives funding support from the City of Seattle's Families and Education Levy.

The Teen Health Center, which is staffed with a Licensed Health Care Provider, a Mental Health Counselor, and a Clinic Coordinator, provides all the services (and more) of a family doctor in a teen friendly setting. These services include mental health counseling, routine physicals, sports physicals, reproductive health care, treatment for acute and chronic illness, immunizations, vision and hearing screening, dental referral, lab tests and pharmaceuticals. We also provide preventive education on tobacco, alcohol and other drug use, injuries and violence. Students have the option to select Neighborcare Health as their health care home and access additional health care services including dental care.

The Teen Health Center is open every day during and after school so your student can be seen at a time that is convenient for his/her schedule. In addition, we work closely with providers at other Neighborcare Health clinics so your student can be easily referred for follow-up medical or dental care at one of their other sites during weekends and school vacations.

To use this service you simply need to complete and sign the attached registration, consent and health history forms and return them to the Teen Health Center.

Support from the Families and Education Levy does not cover the entire cost of the Teen Health Center. If you have health insurance, we ask that you complete that section of the registration form so that we can bill your insurance company. Public insurance (medical coupons) will cover the entire fee for your student's services at the Teen Health Center. However, private insurance company rules may require some out of pocket cost for services for students with private insurance coverage.

If you do not have health insurance, staff at West Seattle Teen Health Center can help you enroll if you qualify. All you need to do is indicate that you have "no insurance" under the insurance section on the registration form and let them know that you would like a Medicaid application. The West Seattle Teen Health Center and Neighborcare Health is committed to serving students regardless of ability to pay.

West Seattle High School is fortunate to have the Teen Health Center and I hope you will take advantage of this resource for your son/daughter. If you would like more information or need assistance with any of the paperwork, please call the West Seattle Teen Health Center at (206) 658-8048.

Sincerely,

Bruce Bivens, Principal



School-Based Health Center Program

Adolescent Health History Form

Student's Name _____ Date of Birth _____ Date Form Completed _____

Signature of Person Completing Form _____

If he or she needs to be seen at the West Seattle Teen Health Center PLEASE CALL (206) 658-8058

PERSONAL HEALTH HISTORY

Has s/he ever had any of the following?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alcohol/drug problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (Jaundice) | <input type="checkbox"/> Serious accident |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Knee or ankle injury | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Learning disability/ADD | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental/emotional problem | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Head/neck injury | <input type="checkbox"/> Positive TB skin test |
| <input type="checkbox"/> Broken bone(s) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure (epilepsy) | |

Other major illnesses, operations, hospitalizations, injuries or conditions (describe and give year) _____

Has s/he had a physical exam within the past 2 years? yes no

Has s/he had a dental visit in the past year? yes no

Is s/he allergic to any medications? yes no If yes, please explain _____

MEDICATIONS

None

Include birth control pills and non-prescription items such as vitamins, pain medication, laxatives, aspirin and herbs.

Medication/Drug Dosage Reason

FAMILY HEALTH HISTORY

Who does the student live with? (Please specify persons by relationship) _____

How many brothers does s/he have? ___ sisters? _____

Is s/he adopted? yes no

For each illness below, please tell us if a family member (grandparent, parent, aunt/uncle, sibling) has had the illness.

	YES	NO	If YES			YES	NO	If YES	
			Mother's side	Father's side				Mother's side	Father's side
• Alcohol problems	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• Heart attack before age 55	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• High cholesterol needing medication	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Drug problems	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Sudden death	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• Stroke before age 55	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	• Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____
• Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____/____	_____/____	List type _____				

Other illnesses or conditions (explain) _____

PLEASE CONTINUE TO NEXT PAGE ➔

NEIGHBORCARE HEALTH - School Based Health Center Program
 Please help us serve you better by providing the following *confidential information*

REGISTRATION FORM

Have you previously registered with this School-Based Health Center? Yes No

NAME: Last (Sr. Jr.)		First	Middle	Previous Last	Nickname
Patient's Social Security Number		Patient's Date of Birth ____/____/____		Patient's Sex (Circle one) MALE FEMALE	
Patient's Address (Street or Post Office Box)		LANGUAGE (Primary language spoken in patient's home):			
City State Zip		<input type="checkbox"/> AMHARIC <input type="checkbox"/> HMONG <input type="checkbox"/> SAMOAN <input type="checkbox"/> ARABIC <input type="checkbox"/> KOREAN <input type="checkbox"/> SOMALIAN <input type="checkbox"/> CAMBODIAN/KHMER <input type="checkbox"/> LAOTIAN <input type="checkbox"/> SPANISH <input type="checkbox"/> CANTONESE <input type="checkbox"/> MANDARIN <input type="checkbox"/> TAGALOG <input type="checkbox"/> ENGLISH <input type="checkbox"/> MIEN <input type="checkbox"/> THAI <input type="checkbox"/> FARSI <input type="checkbox"/> OROMO <input type="checkbox"/> TIGRINIAN <input type="checkbox"/> FRENCH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER Language: _____			
Country	County	Home Phone			
Work Phone		Ext.			
Alternate Phone		Type: _____ (Cell/Other)			
E-mail		Does Student have a Primary Care Doctor/Clinic? (circle one) Yes No If yes, please provide: Provider Name: _____ Phone Number: _____			
I wish to be contacted in the following manner (circle one)		Student ID _____ Grade _____ Student Status (circle one) Full Time Part Time Not a Student Smoker (circle one) Yes No			
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Detailed Information (DI) <input type="checkbox"/> Call Back Number Only (CB)					

Demographic Questions (enter on the Client Defined tab of the Patient Information screen)

Disabled/Handicapped: DOES PATIENT HAVE ONGOING CONDITION PREVENTING DAILY ACTIVITIES: YES NO
Immigrant/Refugee: IS THE PATIENT AN IMMIGRANT OR REFUGEE OR NEW ARRIVAL TO THIS COUNTRY? YES NO
Total Number in household: NUMBER OF FAMILY MEMBERS REPORTED ON FED INCOME TAX RETURN: _____
Total Number of Children <18: NUMBER OF CHILDREN IN THE HOUSEHOLD UNDER AGE 18: _____
Household Status: PATIENT LIVES IN SINGLE PARENT NON-PARTNERED HOUSEHOLD? YES (male) YES (female) NO

Uniform Data System Questions (enter on the UDS tab of the Patient Information screen)

Housing Status: Doubling Up Not Homeless Other Public Housing Shelter Street Transitional Unknown/Unreported
Farm Worker Status (Circle One): Migrant Seasonal Not a Farm Worker
Interpreter Required: Is an Interpreter needed for this Patient? Yes No

Race: <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> UNREPORTED/REFUSED <input type="checkbox"/> MORE THAN ONE RACE <input type="checkbox"/> WHITE		Ethnicity: <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> OTHER
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PARENT, GUARDIAN OR RESPONSIBLE PARTY (Circle One)	PARENT SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	GUARDIAN DATE OF BIRTH / /	OTHER TELEPHONE # (Relationship)
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IN CASE OF EMERGENCY CONTACT: Relationship: Telephone: Address:

_____ _____ _____ _____

Primary Insurance Name: _____

Subscriber Name: _____ Relationship: _____ Subscriber Sex: _____ Subscriber DOB: ____/____/____

Plan #: _____ Policy #: _____ Group #: _____

Group Name: _____ Effective Date: ____/____/____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship: _____ Subscriber Sex: _____ Subscriber DOB: ____/____/____

Plan #: _____ Policy #: _____ Group #: _____

Group Name: _____ Effective Date: ____/____/____

RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to this clinic is currently correct and understand that any deliberate mis-representation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the Medical/Dental staff of the above named clinic to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problems. I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental Assistants, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical/Dental Director. The assignment and release authorizes Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services.



School-Based Health Center Program Consent for Health Services

Neighborcare Health must have a signed Consent Form from a parent or legal guardian before providing services to your student, except in situations where federal and/or state laws allow student to access such treatment without parent/guardian consent. Any individual may independently access reproductive health care at any age and they may independently receive drug and alcohol services and mental health counseling starting at age 13. If necessary, the Health Center will inform students of options for outside care and will assist the student in discussing these issues with parents/guardians.

By signing this Consent Form, you are also granting permission for the school nurse to administer over-the-counter medications (for example, Ibuprophen, Tylenol, Tums, etc.) as prescribed by the Nurse Practitioner of the Health Center. If this is not acceptable, please indicate so in writing on this form.

I hereby request and authorize

Student's First Name	Middle Initial	Last Name	Birth date
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To receive any and all health care services available from and deemed necessary by the staff of the Health Center and it's associated provider agency. These services may include, but are not limited to, mental health counseling, routine medical exams, naturopathy, sports physicals, well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and X-rays and dental screening. Consent is specifically given for care in the event the above named student presents him/herself for treatment in my absence. 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 Health Center and its staff. This authorization does not allow services to be rendered without the student's consent, unless s/he is unable to do so.

With your written authorization, your adolescent may also receive medical services independently at one of Neighborcare Health's medical clinics. I grant permission for my adolescent to receive medical services independently at one or more the following Neighborcare Health medical clinics.

High Point Medical Clinic - 461-6966 45th Street Medical Clinic - 663-3350 Rainier Park Medical Clinic - 461-6957
 Rainier Beach Medical Clinic - 722-8444 Greenwood Medical Clinic - 782-8660

Signature of parent/guardian _____

When consent is provided for care, all information is kept confidential, except in the following circumstances:

- The student gives permission through a signed release of information
- S/he indicates risk of imminent harm to self or others
- S/he has a life threatening health problem and is under the age of 18
- There is reason to suspect abuse or neglect
- Evidence of certain communicable diseases, requiring a report to public health authorities

Consent is given to share necessary information with all health care providers at the Health Center, including exchange of information between the mental health counselor, nurse practitioner and the school nurse, for the purpose of providing the best care for the above-named student.

I also acknowledge that I have received the Neighborcare Health Notice of Privacy Practices that describes how my health information may be used and disclosed and how I may access my information.

I understand the student's consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), and alcohol/drug or mental health counseling. I understand, however, that parents/guardians will be informed if Health Center staff believes the student is a danger to him/herself or to others.

Consent for services are authorized for the length of time the student is enrolled in a school with a Health Center. You may choose to withdraw this consent at any time by writing to the Health Center that serves the student. Should you elect to not sign your adolescent up for Health Center services, s/he may still receive services from the school nurse.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____