Garfield
Teen Health Center

Dear Parents or Guardians of Garfield students:

The Garfield Teen Health Center (GTHC) is sponsored by the Odessa Brown Children's Clinic, the Seattle/King County Public Health Department and Seattle Public Schools with additional funding from the City of Seattle's Families and Education Levy. Medical and mental health professionals from Seattle Children's Hospital and the Odessa Brown Children's Clinic provide services and consultations. Students, school faculty, school administration, parents and community organizations have participated in building a quality health care program for Garfield students.

The services that the clinic offers your child include (but are not limited to):

- Physical exams and health assessments (including sports physicals and other routine exams)
- Immunizations
- Diagnosis and treatment of illness and injuries
- Assessment and counseling related to mental health
- Nutrition consultations
- Family planning and sexually transmitted disease services
- Health education activities
- Assistance in obtaining health insurance

Each student must provide full parental consent in order to receive comprehensive services. Parental consent requires completion of the attached registration form and the signature from the student's legal guardian. All services at GTHC are provided free of charge. GTHC's primary focus is to make health care available to students who do not have health insurance coverage or who have not seen a primary care provider recently.

We are proud of the GTHC and its ability to provide high quality school-based health care to students. We believe this is a unique opportunity for students to learn how to care for their health. Join us in this effort.

Please complete and sign the attached consent form and return it to the Teen Health Center at Garfield High School. Feel free to stop in and meet the clinical staff or call if you have questions about the clinic and its services.

Please sign consent on the other side.

Garfield Teen Health Center
400 23rd Ave, Room 102
Seattle, WA 98122
Phone: 206.860.0480 Fax: 206.860.0680

Odessa Brown Children's Clinic

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

52713

GARFIELD TEEN HEALTH CENTER
CONSENT

PATIENT LABEL HERE

School-based Health Centers
Consent for Health Services

School-based health centers located in Seattle Public Schools must have a signed consent from a parent or legal guardian before providing services to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. If the youth is enrolled in school but is not enrolled in a School-Based Health Center (SBHC), he/she can continue to receive school nurse services.

I hereby request and authorize that:

Print Youth's name: _____ _____
First Name Middle Initial Last Name Birthdate

School: _____ Graduation year: _____

receive health care services available from and deemed necessary by the staff of the SBHC. These services include, but are not limited to, such procedures as well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and x-rays. Consent is also given for referral of care and if needed, emergency transportation to other providers, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the Center and its staff. This authorization does not allow services to be rendered without the youth's consent, unless s/he is unable to provide consent.

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

1. The client gives permission through a signed release of information.
2. If s/he indicates a risk of imminent harm to self and others.
3. S/he has a life threatening health problem and is under the age of 18 years.
4. There is a reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent for services is authorized for the length of time the youth is enrolled in Garfield High School. I may choose to withdraw the consent at any time by writing to the Center that serves the youth.

Youth Signature: _____ Date: _____ Time: _____

Parent/Guardian Signature: _____ Date: _____ Time: _____

Name/Relationship of Legally Responsible Guardian (print): _____

FOR YOUR INFORMATION

Under Washington State law, youth may Independently access reproductive health care at any age without parent/guardian consent (RCW 3.02.100(1 and 2)). They may Independently receive drug and alcohol services and mental health counseling from age thirteen (RCW 70.96A.095, RCW 70.96A.0097, RCW 71.34.530, and RCW 71.34.500) and care for STDs from age fourteen (RCW 70.24.110) without parent/guardian consent. The School-Based Health Center encourages each youth to involve his/her parents or guardians in health care decisions whenever possible.

If necessary, the SBHC will Inform youth of options of and assist youth in accessing outside care. The SBHC will assist the youth in discussing these situations with parents/guardians.

Youth'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 and drug or mental health counseling.

ADOLESCENT PREVENTIVE SERVICES: PARENT/GUARDIAN QUESTIONNAIRE

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken

3. Has your adolescent ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem

4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐		Headaches/migraines	☐	☐	
Allergies/hayfever	☐	☐		Low iron in blood (anemia)	☐	☐	
Asthma	☐	☐		Pneumonia	☐	☐	
Bladder or kidney infections	☐	☐		Rheumatic fever or heart disease	☐	☐	
Blood disorders/sickle cell anemia	☐	☐		Scoliosis (curved spine)	☐	☐	
Cancer	☐	☐		Seizures/epilepsy	☐	☐	
Chicken pox	☐	☐		Severe acne	☐	☐	
Depression	☐	☐		Stomach problems	☐	☐	
Diabetes	☐	☐		Tuberculosis (TB)/lung disease	☐	☐	
Eating disorder	☐	☐		Mononucleosis (mono)	☐	☐	
Emotional disorder	☐	☐		Other: _____	☐	☐	
Hepatitis (liver disease)	☐	☐					

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐		
Arthritis	☐	☐	☐		
Birth defects	☐	☐	☐		
Blood disorders/sickle cell anemia	☐	☐	☐		

Seattle Children's®
HOSPITAL · RESEARCH · FOUNDATION

52679

PATIENT LABEL HERE

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seizures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

Parental/Guardian Concerns

11. Please review the topics listed below. Check(✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity (heterosexual/homosexual/bisexual)	☐
Depression	☐	Work or job	☐
Lying, stealing, or vandalism	☐	Other: _____	☐
Violence/gangs	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No

Student Registration Form (please print)

Student's Last Name:	First Name :	Middle Name:
Street:	City:	State/Zip Code:
Birth Date:	Social Security Number:	Student ID #:
Sex: __Male ___Female	Current Grade/Year: 9 10 11 12 Other_____	Graduation year:
Parent/Guardian Name:	Home Phone #:	Work phone/Cell phone #:
***Allergies (please list and describe reaction).**		
Emergency Contact name:	Relationship to Student:	Emergency Contact Phone #:
Primary Care Provider's name:	Primary Care Provider's Phone #:	
Family e-mail address:	Student's preferred Language:	Families preferred language:

Race/Ethnicity

Which of the following best describes the student's race?

___African-American ___ African Native ___American Indian/Alaska Native __Asian ___Caucasian ___Other/Multi

Which of the following best describes the student's ethnicity (check all that apply):

__Anglo/western European	__Samoan	__Ethiopian	__Somali	__Eritrean	__Other African Native
__Cambodian	__Chinese	__Filipino	__Korean	__Vietnamese	__Japanese
__East Indian	__Other Asian	__Eastern European	__Hispanic/Latino	__Middle Eastern	Other:

Housing Information

Is the student homeless? ___Yes ___No. If yes, please list the city, state and zip code of last permanent residence.

Does the student live in public housing? ___Yes ___No

Does the student live in a single parent, non-partnered household? ___Yes ___No

How many family members under the age of 18 live in the student's residence (including the student)?____

Other Information

Some patients and/or their family members are being hurt or threatened by someone they love. Is this happening to you?_____No ____Yes. (If yes, please explain)

Is violence at home a concern for the student? ___Yes ___No

Is the student an immigrant or refugee or a new arrival to the U.S.? ___Yes ___No

Is the student employed? ___Yes ___No

Does the student have an ongoing disability that would stop her/him from doing daily activities?

___yes ___No (If yes, please explain)

Is the student eligible for the Free or Reduced Lunch Program? ___Yes ___No ____I don't know

Insurance Information

Does the student have insurance? ___Yes ___No

If yes, please complete the information below.

If no, are you interested in learning more about free or low-cost health insurance? ___Yes ___No

Policy Holder's Name:	Policy Holder's Birth date:	Policy Holder's Social Security Number:
Name of Insurance Company (Including Medicaid, DSHS programs):	Policy Number:	Policy Effective Dates:

SEATTLE PUBLIC SCHOOLS

Community Based Organization
Parent/Guardian Consent Form
2015-2016 Approval

Public Health – Seattle & King County
School-Based Partnerships Program
401 5th Ave #1000
Seattle, WA 98104
206.263.8350

Garfield Teen Health Center
Odessa Brown Children's Clinic
(OBCC)/Seattle Children's (SCH)
400 23rd Avenue, Room 102
Seattle, WA 98122
206-860-0480

UW Department of Psychiatry & Behavioral Sciences
1959 NE Pacific Street
Box 356560
Seattle, WA 98195-6560
206-543-3750

Consent to Release of Education Records Under the Family Education Rights and Privacy Act (FERPA)

I consent to the release of my child's education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

1. Student name and contact information
2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
3. Attendance History
4. Discipline History
5. Coursework and grades History
6. Test Scores History
7. Enrollment History
8. Assignment Grades
9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child's academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child's school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health - Seattle & King County, Garfield Teen Health Center/OBCC/SCH staff will work with my child and/or his/her school in an effort to improve my child's success at school. The University of Washington Department of Psychiatry and Behavioral Science will only be granted access to the above educational records for the purpose of maintaining a secure database to store the data. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District's School & Community Partnership Department, MS: 32-159 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2016. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

Parent/Guardian Signature (if youth is 17 or younger): _____

Parent/Guardian Printed Name: _____

Student's Signature (if youth is 18 or older): _____

Today's Date: _____

_____ _____

PRINT Student's Name (First and Last name) Student Date of Birth

_____

Student School District ID # **Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student's school**

For more information please refer to http://communitypartnerships.www.seattleschools.org