

Health Network for Rural Schools

School Health

STUDENT HEALTH REGISTRATION FORM



Registration Date: _____

Student Name: _____

Mailing Address: _____

City: _____ State: OR Zip: _____

Phone: _____ Birth Date: _____

Age: _____ Grade Level: _____

Sex: (Circle) Male Female

Ethnicity: (Circle)

Asian or Pacific Islander

Hispanic

Native American

Non-Hispanic Black

Non-Hispanic White

Other

Parent/Guardian

Name: _____

Phone: Home _____ Work _____

Name: _____

Phone: Home _____ Work _____

Who is child's regular health care provider? (Doctor, Nurse Practitioner) _____

Who is child's regular dentist? _____

Does child have insurance? (Circle) Yes No Unsure

If yes, please circle type: Oregon Health Plan/CareOregon Medicare Private Insurance

Student Health Information:

Allergies: (if any) _____

Chronic Medical Illness: (past/present) _____

Current Medication: (include prescription, over-the-counter, herbal, etc.) _____

Other important health history: (surgeries, significant family health history, social issues, etc.) _____

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

1. I give my permission for the HNRS school nurse and/or nurse practitioner, or trained school staff, to dispense the following over-the-counter medications as treatment for minor health complaints. Please check yes or no for the following treatments:

Yes ___ No ___ Tylenol for headaches, menstrual cramps, muscle pain

Yes ___ No ___ Ibuprofen for headaches, menstrual cramps, muscle pain

Yes ___ No ___ Antacids for stomach ache, nausea, or other minor gastrointestinal complaints

Yes ___ No ___ Cough drops for minor sore throat or cough

Yes ___ No ___ Topical ointments or lotions for bug bites, cuts, minor rashes, itching, etc.

Yes ___ No ___ Antihistamine (Benadryl) for allergic reactions and itching

In the case of all other health services requiring parental consent, you will be contacted prior to provision of treatment.

Health Network for Rural Schools



PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

2. I give my permission for the Health Network for Rural Schools (HNRS) school nurse and/or nurse practitioner to assess and treat the following minor illnesses or injuries without contacting me in advance. These services are not meant to replace your child's personal physician or health care provider, but can be very beneficial. It is my understanding that the health staff will notify me whenever they have provided these services to my child. Please **check yes or no** if you would like your child to receive these services, as needed, from the school nurse or nurse practitioner:

- minor playground or sports injury (such as that requiring a bandage)
- minor rashes or skin irritation; removal of splinter
- insect bites
- eye condition or ear pain
- bloody nose
- headache
- cold symptoms (such as cough, sore throat, or fever)
- stomach complaints or nausea & vomiting
- menstrual cramps

Yes _____ No _____

In the case of all other health services requiring parental consent, you will be contacted prior to provision of treatment.

3. Consent for emergency treatment:

In an emergency, I give my consent for evaluation and treatment as described:

- a) The administration of any first aid and/or medical treatment deemed necessary by a Registered Nurse, Licensed Nurse Practitioner, Licensed Physician, or Dentist.
- b) The transfer to the closest hospital or health clinic when medically necessary and the parent, guardian, or emergency contact person cannot be reached.

4. Privacy Practices Acknowledgement

I acknowledge that OHSU and OHSU Medical Group may use and release health information as described in the notice of privacy practices. I acknowledge that I have received:

- 1) A copy of the OHSU and OHSU Medical Group Notice of Privacy Practices and
- 2) A copy of the Health Network for Rural Schools Policy on Release of Information.

(Full legal name of student)

(Parent/legal guardian signature)

(Date)

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.

Oregon Health & Science University and OHSU Medical Group are committed to preserving the privacy of your health information. In fact, we are required by law to do so for any information created or kept by us. We are also required to provide you with this Notice describing our legal duties and our practices concerning your health information.

Oregon Health & Science University includes the schools of Dentistry, Medicine, Nursing, and Science & Engineering; OHSU Hospital, and Doernbecher Children's Hospital; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach programs. For the rest of this Notice, "OHSU" will refer to all services, service areas, and workers of Oregon Health & Science University and OHSU Medical Group.

A. PURPOSE OF THIS NOTICE.

This Notice tells you how OHSU uses and discloses the health information that you have given us or that we have learned from you when you were a patient in our system. It also tells you about our responsibility to you and how we can and cannot use your health information.

Note: When we use the words "your health information," we mean any information that you have given us about you and your health, as well as information that we have gathered while we have taken care of you (including health information provided to OHSU by those outside OHSU). OHSU will follow this Notice of Privacy Practices and any future changes to the Notice that we are required or authorized by law to make. We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. We will have a copy of the

current Notice with an effective date in clinical locations and on our website at www.ohsu.edu/cc/hipaa.

The health information practices listed in this Notice will be followed at all OHSU hospitals, OHSU clinics and other OHSU locations. This includes the practices of:

- All OHSU employees, volunteers, students, residents and service providers, including clinicians, who have access to health information.
- Any health care professional authorized to enter information into your OHSU health record.
- Any non-OHSU clinicians who might otherwise have access to your health information created or kept by OHSU, as a result of, for example, their call coverage for OHSU clinicians.

The people listed above will share your health information with each other for purposes of treatment, payment, and healthcare operations, as further described in this Notice.



B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AT OHSU.

1. Treatment, Payment and Health Care Operations.

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

a. For Treatment. We may use your health information to provide you with medical or dental treatment or services. We may disclose your health information to staff physicians, staff dentists, post-graduate fellows, midwives or nurse practitioners, and other personnel involved in your health care. We may also disclose your health information to students and resident physicians who, as a part of their OHSU educational programs (and while supervised by physicians or dentists), are involved in your care. Treatment includes (a) activities performed by nurses, office staff, hospital staff, technicians and other types of health care professionals providing care to you or coordinating or managing your care with third parties, (b) consultations with and between OHSU providers and other health care providers, and (c) activities of non-OHSU providers or other providers covering an OHSU practice by telephone or serving as the on-call provider.

For example, a physician or dentist treating you for an infection may need to know if you have other health problems that could complicate your treatment. That provider may use your medical history to decide what treatment is best for you. They may also tell another provider about your condition so that he or she can decide the best treatment for you.

b. For Payment. We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from OHSU. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For example, we may need to give your health plan information about surgery you received at OHSU so your health plan will pay us or reimburse you for the surgery.

c. For Health Care Operations. We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at OHSU. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective. Or we may give health information to doctors, nurses, technicians, or health profession students for review, analysis and other teaching and learning purposes.

2. Special Circumstances. Treatment, payment and health care operations at OHSU include uses and disclosures in the circumstances listed below.

a. Appointment Reminders. We may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or services.

b. Treatment Alternatives and Health Related Products and Services. We may use and disclose your health information in order to allow someone to contact you about possible treatment options or alternatives, or health related products or services that may be of interest to you. For example, an OHSU provider may contact you with information about a health service that may benefit you after your discharge from the hospital.

c. Fundraising Activities. We may use and disclose a limited amount of your health information internally, or to the OHSU Foundation and Doernbecher Children's Hospital Foundation to allow them to contact you to raise money for OHSU. The health information released for these fundraising purposes will include your name, address, phone number and dates on which you received service at OHSU.

3. Uses and Disclosures You Can Limit

a. Hospital Directory. Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital. Specifically, your name, location in the hospital and your general condition (e.g., good, fair, serious, critical) may be released to people who ask for you by name. In addition, your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name.

b. Family and Friends. Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room during treatment.

Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care. For example, we may tell someone who comes with you to the emergency room that you suffered a heart attack and provide updates on your condition. We may also make similar professional judgments about your best interests that allow another person to pick up such things as filled prescriptions, medical supplies and X-rays.

C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

- 1. Required By Law:** As required by federal, state, or local law.
- 2. Public Health Risks:** For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- 3. Health Oversight Activities:** To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- 4. Lawsuits and Disputes; Law Enforcement:** In response to a subpoena or a court or administrative order, if you are involved in a lawsuit or a dispute, or in response to a court order, subpoena, warrant, summons or similar process, if asked to do so by law enforcement.

5. Coroners, Medical Examiners and Funeral

Directors: To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.

6. Organ and Tissue Donation: To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.

7. Research: For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process.

8. Serious Threat to Health or Safety; Disaster

Relief: To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to notify your family members or persons responsible for you in a disaster relief effort.

9. Military and Veterans: As required by military command or other government authority for information about a member of the domestic or foreign armed forces.

10. National Security; Intelligence Activities;

Protective Service: To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

11. Workers' Compensation: To your employer via a workers' compensation or similar work-related injury program.

12. Inmates: To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that person's custody) as necessary (a) for the institution to provide you with health care; (b) to protect your or others' health and safety; or (c) for the safety and security of the correctional institution.

D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us

your specific written authorization to do so. If you give us authorization, you can withdraw this written Authorization at any time. To remove your authorization, deliver or fax a written revocation to OHSU Health Information Services, Mail Code OP17A, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201; fax: (503) 494-6970. If you revoke your Authorization, we will no longer use or disclose your health information as allowed by your written Authorization, except to the extent that we have already relied on your Authorization.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have certain rights regarding your health information which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing by completing a form that you can obtain from the OHSU Integrity Office, at 2525 S.W. First Ave., Suite 140, Portland, OR 97201, or on the Web at www.ohsu.edu/cc/hipaa. In some cases, we may charge you for the costs of providing materials to you. You can get information about how to exercise your rights and about any costs that we may charge for materials by contacting the OHSU Integrity Office at (503) 494-0219.

- 1. Right to Inspect and Copy.** With some exceptions, you have the right to inspect and get a copy of your health information that may be used to make decisions about your care. We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
- 2. Right to Amend.** You have the right to amend your health information maintained by or for OHSU, or used by OHSU to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create, (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.

3. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of certain disclosures we made of your health information. The list does not include all disclosures. For example it does not include disclosures to you, disclosures for treatment, payment, and health care operations purposes described above, or disclosures made with your Authorization as described above.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health care operations, or (b) to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, and any time OHSU agrees to a restriction, it must be in writing and signed by the OHSU Privacy Officer or his or her designee.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain place. For example, you can ask that we only contact you at work or by mail.

6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, whether or not you may have previously agreed to receive the Notice electronically.

F. QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact OHSU (503) 494-8311. If you believe your privacy rights have been violated, you may file a complaint with OHSU or with the Secretary of the Department of Health and Human Services. To file a complaint with OHSU, contact OHSU at (503) 494-8311. You will not be penalized for filing a complaint.

**This notice tells you how we may use and share health information about you.
If you would like a copy of the OHSU notice, please ask your health care provider.**



Oregon Health & Science University includes four schools; OHSU Hospital and Doernbecher Children's Hospital; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach units.

OHSU is an equal opportunity, affirmative action institution. OHSU-NPP-0403. Reorder from Relizon. Order Number 133201.

Health Network for Rural Schools Policy on Release of Information

If your child receives individualized health services from the Health Network for Rural Schools (HNRS) school nurse, nurse practitioner, or student assistance counselor, any records pertaining to these services will be maintained in a separate, confidential student health record. The student health record is separate from your child's education record. The following policies on release of information apply only to the student health record:

1. Information in the student health record is confidential and may only be shared with school personnel who have a legitimate educational interest or with others (such as the student's personal health care provider or an attorney) when the parent and/or child (if he/she is over the age of 18 or legally emancipated) has provided written consent. Individuals who have a legitimate educational interest are those who have a need to understand the student's health condition for educational planning or to provide health care or emergency care.
2. Medical records that are obtained by parental consent from other health care providers or agencies may not be released to a third party.
3. Parents and students will be informed of the policy on information shared annually. **A signed acknowledgement must be received before health services are provided to the student.**
4. The student and/or his or her parent or legal guardian (if the student is a minor) have the right to review the student health record. It is the policy of the HNRS that the appropriate professional staff will be present when the record is reviewed and will assist the student or parent to understand the material included in the record.

Please note that the school district also maintains certain student health information in your child's education record. These records are handled differently and the policies listed above may or may not pertain to the education record. If you have questions concerning the education record, please speak with the school office. The information that is included in the education record includes: a) results of health screening (height/weight, vision, hearing, scoliosis, dental), b) the immunization record, c) the TB clearance certificate (if required by law according to the student's birth county), d) the health management plan prepared by a nurse for students with special health needs, e) any communications related to health and safety and directed to the school from parent or health care provider, and f) the medication administration records if related to an Individual Education Plan (IEP).

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