Northern Cheyenne School Based Health Centers
Parent/Legal Guardian Consent Form

School: □ Lame Deer Elementary □ Lame Deer Middle School □ Lame Deer High School
□ Northern Cheyenne Tribal School (Busby) □ Head Start □ St. Labre Indian School
□ Colstrip □ Home Schooled/Other

Student/Patient Information

Legal Name:_____Date of birth:_____M:☐ or F: ☐
Grade:____Address:_____
Cell Phone:_____Home:_____Email:_____

What is your child's race/ethnicity?
Please select all that apply:

- American Indian, Alaska Native or Indigenous
- Asian
- Black or African American
- Hispanic or "Latino, Latina or Latino"
- Native Hawaiian or Other Pacific Islander
- White
- "Prefer to self-describe _____"

Legal Guardian Information

Name:_____
Address:_____
Home Phone:_____Cell:_____Work:_____
Email:_____

Preferred Method of Contact: □ Email □ Phone □Text

Is the student an IHS Beneficiary? □ Yes □No

Healthcare Provider _____ Phone_____
Dental Provider _____Phone_____

I have health insurance: □ Yes □No

I have public or private insurance: □ Public □Private

If yes to health insurance, select one:

Insurances	Choice
Medicaid/Healthy Montana Kids+	

Healthy Montana Kids/CHIP (BCBS)	
Other	

I have an insurance card on file with the school: □ Yes □No

Medical and Dental History

1. Has your child had a dental cleaning in the past 6 months? ⌑ Yes ⌑ No
2. Date of Last Dental Visit? _____
3. Date of last dental X-rays?_____
4. Do you have an upcoming dental visit already scheduled with your dental provider?
   ⌑ Yes ⌑ No

5. Is your child experiencing any tooth related issues?
   ⌑ Pain or irritation or sensitivity
   ⌑ Toothache (throbbing)
   ⌑ Sore gums
   ⌑ Cosmetic concerns
   ⌑ Bad breath
   ⌑ Other _____

6. Has your child ever had a serious health problem? ⌑ Yes ⌑ No
   If Yes, please describe: _____

7. Has your child ever had a surgery? ⌑ Yes ⌑ No
   If Yes, please describe: _____

8. Has your child been seen in the emergency room in the past year? ⌑ Yes ⌑ No

9. Is your child taking any prescription or non-prescription medications? ⌑ Yes ⌑ No
   If Yes, please list: _____

10. Does your child have any allergies (e.g., drug/medicine, latex, nuts, silver, etc.)? ⌑ Yes ⌑ No
    If Yes, please describe: _____

11. Does any of your child's immediate family have a history of heart disease or diabetes?
    ⌑ Yes ⌑ No
    If so, which one (which disease), and which family member?
    -
    -
    -

12. Is there anything else we should know about your child prior to treatment?

I/We have read and understand the services offered at the School Based Health Center as described below. I/We understand that the services authorized by my/our signature on this form are limited to routine health services and treatment which may include, but are not limited to:

1. Diagnosis/treatment of minor and acute illnesses, first aid for minor injuries
2. Assistance with chronic (on-going) illness(es) management
3. Physical examinations for well-checks, sports, or pre-employment clearance
4. Over the counter and basic prescription medications
5. Health screenings
6. Education concerning nutrition, drug and alcohol abuse prevention, violence prevention, mental health, exercise, sexually transmitted disease, and pregnancy prevention
7. Dental care including: cleaning, fluoride varnish, silver diamine fluoride*, screening and assessment, dental sealants, x-rays when prescribed by dentist, intra-oral images
8. Vaccinations according to CDC-recommended schedules
9. Mental healthcare
10. Referrals for health services which cannot be provided at this center
11. Referrals for social services include legal assistance

silver diamine fluoride will darken tooth decay and harden the tooth surface. Healthy tooth structure will not darken. If accidentally applied to the skin or gums, it may temporarily stain but can cause no harm.

Please note: Montana State Law (Montana Code: 41-1-402) permits for the provision of certain services to adolescents with or without parental consent. These services include prevention, diagnosis, and treatment of pregnancy, any reportable communicable disease, including a sexually transmitted disease, or drug and substance abuse including alcohol.
Please list any services offered at the School Based Health Center that you **do not want** your child/ward to receive:

_____

_____

I/We understand that this consent covers only those services provided at the School Based Health Centers and no other private or public health facility. I/we hereby authorize a licensed health care provider (physician, advanced practice registered nurse, physician assistant, etc.) and other professional Health Center staff to provide necessary and/or advisable treatment for my child/ward. This student has my/our permission to receive all services offered at the School Based Health Center, except those that I/we have specifically excluded above.

Medical records will be kept confidential. However, I/we acknowledge that the services for my child/ward's condition may require the collaboration of other agencies and service providers. I/We understand that this collaboration may require the disclosure of the information about my child/ward to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School Based Health Center may be required to release information regarding treatment to third-party payers for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else, and (3) If a student claims someone is physically, sexually, or emotionally abusing her/him.

Additionally, as part of the training and education of future providers, a nurse practitioner student may be present during the examination. By checking the box, you acknowledge that you understand the following:

- A nurse practitioner student may be present during the examination.
- The student will observe and may assist under the supervision of the healthcare provider.
- You/your child have the right to decline the student's presence at any time.

Consent:

- I, the undersigned, consent to the presence of a nurse practitioner student during examinations

By signing below, you are consenting to the following:

- I, parent/legal guardian/self-consenting minor below, authorize the School District to grant the School Based Health Center, the on-site provider at my child's school, authorization to review my child/ward's student records. The School Based Health Center agrees not to disclose the student's records to any other person or entity without first obtaining my written permission.
- I understand that the School Based Health Center may share my child's information with my child's provider for the purpose of medical evaluation and treatment. This consent form will remain in effect until this student's enrollment terminates, or until I/we revoke this contract in writing.
- I have been given and read the HIPAA privacy rule (see below).

If you are under the age of 18 years old and signing this document as a self-consenting minor, you must meet one of the definitions for self-consenting minors as set forth in MCA 41-1-402. "Validity of consent of minor for health services".

_____ _____

Signature Parent/Legal Guardian/Self-Consenting Minor Date

_____

Printed Name

HIPAA Privacy Rule

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html

Notice of Privacy 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. With your consent, the program is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes: Clinical staff obtains information about you and records it in a health record. During the course of your treatment, the clinical staff determines a need to consult with another health care professional in the area. The clinical staff will share the information with health care professionals to obtain input.

Example of use of your health information for payment purposes: The program may submit a request for payment to Medicaid/CHIP and/or your insurance company. Medicaid/CHIP or the insurance company may request information from us regarding the dental care provided. We will provide information to them about you and the care given.

Example of use of your information for health care operations: The program tracks internal information regarding the

populations served by the program through detailed measurements to include but are not limited by quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, insurance filings and outreach assessments. We will share information about you with our partners as necessary to obtain services, program review and funding opportunities.

The health and billing records we maintain are the physical property of the program. The information in it, however, belongs to you. You have a right to: ·

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to the tour office. We are not required to grant but we will comply with any request granted
- Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to the program
- Appeal a denial of access to your protected health information except in certain circumstances
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to the program
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the program. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to family members or friends in the course of providing care
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
- Revoke authorization that you made to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to the program.

Our Responsibilities
The program is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this Notice
  - Notify you if we cannot accommodate a requested restriction or request
  - Accommodate your reasonable requests regarding methods to communicate health information with you.

The program reserves the rights to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information changes, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice".

If you have questions, and would like additional information, or want to report a problem regarding the handling of your information please write to:
Northern Cheyenne Tribal Board of Health
Employment Services Director
Tanya Camacho
Tanya.camacho@nctribalhealth.com

You may also file a complaint by mailing it or emailing it to the Secretary of Health and Human Services.
The program cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment. Nor will the program retaliate against you for filing a complaint.

Parent/Guardian Consent for Student Nurse Practitioner to Provide Healthcare at School-based Health Clinics

Guardians, Please read carefully and sign below.

Purpose: This consent form authorizes a Doctor of Nursing Practice (DNP) student at Montana State University College of Nursing, to observe and/or provide healthcare services to my child, [Child's Name]_____ , at the Northern Cheyenne Tribal Health School-Based Health Center.

Authorization: I hereby authorize the DNP student to:

- **Examine my child:** This includes taking medical histories, conducting physical examinations, and assessing my child's overall health.
- **Diagnose and treat illnesses and injuries:** This may involve prescribing medications, recommending over-the-counter medications, or referring my child to other healthcare providers as needed.
- **Provide preventive care:** This includes immunizations, well-child check-ups, and health education.

Supervision: Please be assured that DNP students will be supervised by a licensed nurse practitioner or physician.

Confidentiality: All information obtained during the course of care will be kept confidential in accordance with HIPAA regulations.

Emergency Care: In the event of an emergency, the DNP student is authorized to provide necessary emergency care to my child.

Withdrawal of Consent: I understand that I may withdraw this consent at any time, in writing, by notifying the School-Based Health Center.

Signature:

[Parent/Guardian Signature] _____

[Date] _____

Printed Name: _____

Relationship to Child: _____

Child's Date of Birth: _____