WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Dear Hiram Johnson High School Parents and Guardians,

The Hiram Johnson Community Health Center provides a free, convenient and youth friendly place for students to receive health care services here at school. We offer comprehensive medical, dental, mental health, health education and youth development services.

We are located at:

WellSpace Health School Based Health Center
Hiram Johnson High School
3535 65th Street Bldg. C Sacramento, CA 95820
Medical: (916)737-5555 Dental Direct Line (916)318-6221

Every student at Hiram Johnson High School is eligible for medical services at the Health Center. If you feel that your child needs to be seen by a medical or dental practitioner, please have the student reach out to the School Nurse located in room F-1. The student may also go directly to our offices after school hours on Wednesday or Thursday to schedule an appointment with our receptionist.
Please note for dental services, students must be assigned to a WellSpace Health Center location prior to been seen at Hiram Johnson Health Center. Please call our dental phone line for any questions or assistance with this process.

Hiram Johnson Community Health Center Hours of Operation
Monday, Tuesday and Friday: 8:00am-3:00pm
Wednesday: 1:00pm-5:00pm
Thursday: 8:00am-5:00pm

Attached to this letter are two parent consent forms; one for medical and one for dental services, and a medical history form. Both of the consent forms outline in detail the services we provide. If you would like to authorize your son/daughter to utilize the Hiram Johnson Community Health Center, please *complete the packet in full* and return it to the Health Center or give the form to the School Nurse. By signing the parent consent, you are giving your student permission to access the Health Center *during school hours* as needed.

The Hiram Johnson Community Health Center is part of WellSpace Health, a human services organization, who has served Sacramento County and surrounding areas since 1953. Our programs improve the emotional, psychological and physical health of children, youth and families. Other programs include integrated behavioral health care services, substance abuse counseling, women's health and parenting support. All services are provided by a variety of staff, therapists and interns. All staff and volunteers provide services commensurate with their experience, training and supervision.

WellSpace Health is honored to be able to serve students and families at Hiram Johnson High School and we look forward to serving you.

Sincerely,

Magda Chavez
School Based Health Center Coordinator
machavez@wellspacehealth.org

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

GENERAL CONSENT FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Name of Student: ______________________________________Grade: ________ Track: ________

Address: ____________________________________City: ______________________________

Home Phone Number: ____________________________Birth Date: ________________________

School: ______________________________ **Student's SS#**:____________________

Parent/Legal Guardian Emergency/Work Phone No: ___________________________________

I have read and understand the services offered at the above-named health centers ("WellSpace Health"). I hereby authorize the Health Center to provide my son or daughter with simple, common, and routine health care services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

Consent must be given for the following services:

1. Diagnosis and treatment of minor and acute illnesses	8. Vision and hearing screening
2. Diagnosis and treatment of mental health issues	9. Laboratory Services
3. First aid for minor injuries	10. Limited x-ray services at WSHC Health Centers
4. Physical examinations	11. Over-the-counter items/Prescriptions
5. Assistance with chronic ongoing illnesses, such as: asthma, diabetes, and epilepsy	12. Diet and weight control programs
6. Treatment of acne and other skin problems	13. Referral for health care services that cannot be provided at the Health Center
7. Immunizations	14. Emergency treatment

1. I understand that this consent only applies to services provided at the Hiram Johnson School Based Health Center or another WellSpace Health Centers (WSHC) Clinic which is a result of a referral made by the Hiram Johnson School Based Health Center and does not allow any other private or public facility to provide services to my son or daughter.
2. I hereby authorize WSHC to give my insurance carrier(s) medical or dental record information needed to complete my son or daughter's insurance claims.
3. I understand that my son or daughter's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my son or daughter's care and treatment. No other release of my son or daughter's health information is allowed without written permission by me, except as permitted or required by law. I understand that the Hiram Johnson School Based Health Center and WSHC's privacy policy is published in the WSHC Notice of Privacy Practices.
4. I understand that this consent may be revoked, restricted or revised at any time **in writing** by me, however, this will not affect services and/or treatment previously provided by WSHC and other prior reliance by WSHC on this consent.

This Consent Form remains in effect until enrollment at High School terminates, or until revoked in writing.

Signature of Parent/Legal Guardian/: __________________________Date: ___________

Printed Name: ____

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Medical Insurance and Financial Information

I request and authorize direct payment to the Hiram Johnson School Based Health Center and WSHC of any insurance benefits (HMO, private insurance, Medicare, Medi-Cal, etc.) otherwise payable to or on behalf of my son or daughter for services rendered by the Hiram Johnson School Based Health Center and WSHC at a rate not to exceed the actual charges for those services. I understand that neither my son nor daughter will be charged directly for services provided by the Hiram Johnson School Based Health Center and WSHC. I understand that the Health Center will seek payment from all third party payment sources and/or grant funds such as Medi-Cal and Family Pact. Students may be asked to register for Medi-Cal. Family income is usually not a factor in determining eligibility, rather eligibility depends on the type of medical or mental health service utilized by the student. If my son or daughter is covered by any type of health insurance, I will provide insurance information to the Health Center.

Signature of Parent/Legal Guardian/: ______________________________________ Date:____________

Printed Name: ____

While no charge will be made directly to you for any health services provided on school premises, the Health Center is permitted to recover payment for such services from third party payors; therefore, we ask that you supply the insurance information for your son or daughter requested below.

Medi-Cal/Medicaid # (if applicable):____

Insurance Name under Medi-Cal: ____

Other Health Insurance Name & Address:____

Name of Insured:____

Social Security No. of Insured:____

Insurance Effective Date(s):____

Signature verified by (office use only)__________________________________ Date:_______________

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

HIRAM JOHNSON SCHOOL BASED HEALTH CENTER

MEDICAL HISTORY

Student's Name: ______________________________ Birthdate: ______________________________
Address: ______________________________ Sex: ________Age:______________________________
Parent's Name: ______________________________ Phone: ______________________________
Emergency Contact: ______________________________ Phone: (H) ________________ (W) ________________
Private Physicians: ______________________________ Phone: ______________________________

Current Medications:
Is your daughter/son presently taking medications? Yes_________ No__________
If yes, for what condition are they being taken? ______________________________
Type of Medication: ______________________________
Does your child take BISPHOSPHONATES? Yes_________ No__________

Surgery (Age, Type):______________________________
Allergies: Yes__________ No__________ If yes, what are they? ______________________________
Immunizations:

Polio	Yes___	No___	Date______________	Measles	Yes___	No___	Date_________
Tetanus	Yes___	No___	Date______________	Rubella	Yes___	No___	Date_________
Mantoux Test	Yes___	No___	Date______________	Rubeola	Yes___	No___	Date_________
(TB)	Yes___	No___	Date______________	Mumps	Yes___	No___	Date_________

Other: ______________________________
Has your daughter/son had an adverse or bad reaction to any of these immunizations?
Specify______________________________

Prior/Current Illness:			Comments (age, complications)
Chicken Pox	Yes___	No___	______________________________
Measles	Yes___	No___	______________________________
Mumps	Yes___	No___	______________________________
Pneumonia	Yes___	No___	______________________________
Asthma	Yes___	No___	______________________________
Other	Yes___	No___	______________________________
Seizure	Yes___	No___	______________________________
Diabetes	Yes___	No___	______________________________
High Blood Pressure	Yes___	No___	______________________________
Migraines	Yes___	No___	______________________________
Bleeding Tendency	Yes___	No___	______________________________
Heart Disease	Yes___	No___	______________________________

Other______________________________
Describe______________________________

Orthopedic Problems			
Fractures	Yes___	No___	______________________________
Sprains	Yes___	No___	______________________________
Scoliosis	Yes___	No___	______________________________
Concussion	Yes___	No___	______________________________
Knee Injury	Yes___	No___	______________________________
Neck/Spine Injury	Yes___	No___	______________________________

Other: ______________________________

See Reverse

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

STUDENT MEDICAL HISTORY CONTINUED

Biological Family Medical History - Father, Mother, Other Children

		(Specify Who)
Seizures	Yes__ No___	____________________________
High Blood Pressure	Yes__ No___	____________________________
Migraines	Yes__ No___	____________________________
Heart Disease	Yes__ No___	____________________________
Bleeding Tendency	Yes__ No___	____________________________
Diabetes	Yes__ No___	____________________________
Cancer	Yes__ No___	____________________________
Tuberculosis	Yes__ No___	____________________________
Sickle Cell Anemia	Yes__ No___	____________________________
Smoking	Yes__ No___	____________________________
Other	____	

I have completed the Medical History Form to the best of my knowledge.

_______________________________________ _______________________________________

(Print) Name of Parent/Legal Guardian **(Signature) of Parent/Legal Guardian**

Signature verified by (office use only) _____________________________________ Date: ______________

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

GENERAL CONSENT FOR DENTAL TREATMENT AND PAYMENT

Name of Student: ____Grade: ________ Track: ________

Address: ______________________________________City: _______________________________

Home Phone Number: ______________________________Birth Date: _________________________

School: ________________________________ **Student's SS#**:_____________________

Parent/Legal Guardian Emergency/Work Phone No: _____________________________________

I have read and understand the services offered at the above-named health centers ("WellSpace Health"). I hereby authorize the Health Center to provide my son or daughter with simple, common, and routine dental services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

Consent must be given for the following services:

1. Dental Screening	7. Fluoride Varnish
2. Full Exam (Including full mouth X-rays)	8. Sealants
3. Diagnosis and Treatment	9. Prophylaxis/ Cleaning
4. Restorations (Composite or Amalgam)	10. Dental Education
5. Extractions	11. Referrals
6. Root Canal Therapy	12. Other Necessary Dental Procedures

1. I understand that this consent only applies to services provided at the Hiram Johnson School Based Health Center or another WellSpace Health Centers (WSHC) Clinic which is a result of a referral made by the Hiram Johnson School Based Health Center and does not allow any other private or public facility to provide services to my son or daughter.
2. I hereby authorize WSHC to give my insurance carrier(s) medical or dental record information needed to complete my son or daughter's insurance claims.
3. I understand that my son or daughter's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my son or daughter's care and treatment. No other release of my son or daughter's health information is allowed without written permission by me, except as permitted or required by law. I understand that the Hiram Johnson School Based Health Center and WSHC's privacy policy is published in the WSHC Notice of Privacy Practices.
4. I understand that this consent may be revoked, restricted or revised at any time **in writing** by me, however, this will not affect services and/or treatment previously provided by WSHC and other prior reliance by WSHC on this consent.

This Consent Form remains in effect until enrollment at High School terminates, or until revoked in writing.

Signature of Parent/Legal Guardian/: ______________________________________ **Date:** ___________

Printed Name: ____

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Dental Insurance and Financial Information

I request and authorize direct payment to the Hiram Johnson School Based Health Center and WSHC of any insurance benefits (HMO, private insurance, Medicare, Medi-Cal, etc.) otherwise payable to or on behalf of my son or daughter for services rendered by the Hiram Johnson School Based Health Center and WSHC at a rate not to exceed the actual charges for those services. I understand that neither my son nor daughter will be charged directly for services provided by the Hiram Johnson School Based Health Center and WSHC. I understand that the Health Center will seek payment from all third party payment sources and/or grant funds such as Medi-Cal and Family Pact. Students may be asked to register for Medi-Cal. Family income is usually not a factor in determining eligibility, rather eligibility depends on the type of medical or mental health service utilized by the student. If my son or daughter is covered by any type of health insurance, I will provide insurance information to the Health Center.

Signature of Parent/Legal Guardian: ____ Date:_____________

Printed Name: ____

While no charge will be made directly to you for any health services provided on school premises, the Health Center is permitted to recover payment for such services from third party payors. Therefore, we ask that you supply the insurance information for your son or daughter requested below.

Medi-Cal/Medicaid # (if applicable):____

Insurance Name under Medi-Cal: ____

Other Health Insurance Name & Address:____

Name of Insured:____

Social Security No. of Insured:____

Insurance Effective Date(s):____

Signature verified by (office use only)____________________________________ Date:________________

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Dental Materials Fact Sheet Acknowledgement

Patient Name: ________________________________ DOB: _________________

I hereby acknowledge that a copy of the Dental Materials Fact Sheet dated May 2004 has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

If you would like a copy of the Dental Materials Fact Sheet, please come to our Health Center and it will be provided to you.

Signature of Parent/Legal Guardian: _________________________Date:__________

Hoja Informativa De Reconocimiento De Materiales Dentales

Nombre del paciente: _____________________ Fecha de Nacimiento: ________

Reconozco que una copia de la hoja informativa de materiales dentales con fecha de mayo de 2004, se ha puesto a mi disposición. Se me ha dado la oportunidad de preguntar cualquier pregunta que yo pueda tener sobre esta hoja informativa.

Si desea una copia de la Hoja Informativa De Reconocimiento De Materiales Dentales, por favor venga a nuestro Centro de Salud y será proporcionado a usted.

Firma del padre/guardián legal: _________________________ Fecha: ___________

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ____________________________________ Date of Birth: _____________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such as authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: _______________

Relationship to patient (if signed by parent/legal guardian of patient):_______________________

WellSpace Health
Hiram Johnson High School Community Health Center
3535 65th St. Building C, Sacramento, CA 95820
(916) 737-5555 Fax: (916) 451-1706

Consent Forms Packet Checklist

	Fully Complete YES	NO
1. Read Introduction Letter of Health Services Pg.1…………………		
2. **MEDICAL** Consent Form with parent signature and date Pg. 2 …		
3. Medical insurance information with parent signature/date Pg.3…..		
4. Student medical history completely fill out Pg.4 and Pg.5………....		
5. **DENTAL** Consent Form with parent signature and date Pg.6……		
6. Dental insurance information with parent signature/date Pg.7…….		
7. Dental Materials Fact Sheet Acknowledgement Pg.8…….............		
8. Notice of Privacy Practices Patient Acknowledgement Pg.9……..		

Please keep page one
Return the rest of the forms to the Health Center or to the School Nurse