Health, Housing & Community Services
Berkeley High School Health Center

WELCOME TO THE
BERKELEY HIGH SCHOOL/B-TECH HEALTH CENTERS

We invite your student to take advantage of our free services offered at the Berkeley High School and B-Tech Health Centers. The Health Centers are collaborative programs between the City of Berkeley Health, Housing & Community Services Department and the Berkeley Unified School District.

Since 1991, the BHS Health Center has offered free and confidential medical and mental health services to all high school students enrolled in Berkeley High School, Berkeley Technology Academy, and Independent Studies. The B-Tech Health Center opened in January, 2009. (See bottom of page for description of services).

WHAT IS IN THIS PACKET?

- **A Parent Consent Form and Medical History Form**. **In order for your child to receive many of our services, including treatment by our First Aid Nurse, YOU MUST COMPLETE AND SIGN BOTH OF THESE FORMS AND RETURN THEM TO THE HEALTH CENTER**.
- **A Health Care Provider's Disclosure** informing parents that your child's Immunization Record is input into the California Immunization Registry. **If you object, please sign and return the form.**

Please remember:

1) ***If you have filled out Parent Consent and Medical History Forms in the past and your child is already receiving medical services at the Berkeley High School Health Center***, you do **NOT** need to complete these forms again, unless any information has changed. If you are not sure, then please go ahead and fill them out again.

2) You MUST sign the bottom of BOTH the Consent Form and the Medical History Form for your child to receive First Aid services at the Health Center.

3) If you have any questions after reviewing the information enclosed, please call us at (510) 644-6965.

BERKELEY HIGH SCHOOL/B-TECH HEALTH CENTER SERVICES

Medical
- First Aid
- Physicals and Sports Exams for students without medical insurance
- Family Planning and STI prevention, testing and treatment
- Immunizations
- Assistance with referrals for primary care and insurance

Health Education
- Pregnancy/STI/ HIV Prevention
- Substance Abuse Prevention
- Positive Decision Making and Communication Skills
- Healthy Nutrition

Mental Health (BHS site only)
- Crisis Intervention
- Individual Short Term Counseling
- Support Groups

Last updated 06/13

Berkeley High School Health Center
PARENT/LEGAL GUARDIAN CONSENT

Student Name: _____ Year of Graduation _____ Birthdate:_____

I/We have read and understand the services offered at the Berkeley High School Health Center as described in the attached information. I/We understand further that the services authorized by my/our signature on this form are simple, common or routine health care services, and treatment will be limited to:

- Diagnosis and treatment of minor illnesses and first aid for minor injuries
- Sports physical examinations for uninsured students
- One-time general medical exams (CHDP exams) for uninsured students
- Short-term assistance with chronic illness management and referrals for ongoing care
- Immunizations (separate consent required)
- Prescription and over-the-counter medications
- Education relating to diet and weight control, drug and alcohol prevention, mental health, sexuality and pregnancy prevention, including abstinence
- Referrals for health care services which cannot be provided at the School Health Center

CALIFORNIA MINOR CONSENT LAW allows a minor who is 12 years of age or older to receive the following services without parental consent:

- **Prevention, diagnosis and treatment of sexually transmitted infections, including HPV and HepB vaccines**
- **Pregnancy testing, contraceptives, options counseling, and referral for pregnancy related services**
- **Crisis mental health counseling**
- **Alcohol and substance abuse prevention education and referrals**

- I UNDERSTAND THAT NO STUDENT OR HIS/HER FAMILY WILL BE CHARGED DIRECTLY FOR SERVICES DELIVERED AT THE HEALTH CENTER.
- I/We understand that this consent covers only those services provided at this clinic, and does not authorize services rendered at any other private or public facility
- I realize that Health Center staff will coordinate with the student's primary care provider to ensure continuity of care and will refer ongoing care needs to the student's regular physician
- I have completed the attached medical history form to the best of my knowledge. This consent form remains in effect until enrollment at Berkeley High School/B-Tech terminates, or until revoked in writing
- I/We hereby authorize professional clinic staff to provide necessary and/or advisable treatment for my son/daughter
- I understand that the BHS/B-Tech Health Centers participate in a county-wide evaluation of School Based Health Centers, conducted by University of CA, SF (UCSF). Information is collected on the students who use our services, and shared with UCSF **without any names or identifying information**. I understand that BHS/B-Tech Health Centers will never share my child/guardian's personal information with the evaluators without my permission
- I understand that I cannot deny my child the right to receive those services mandated by California Minor Consent Law (above)
- This student has my/our permission to receive all services offered at Berkeley High School Health Center **EXCEPT those which I have specifically excluded below*:***

_____

THIS FORM MUST BE SIGNED BEFORE YOUR CHILD CAN RECEIVE ANY SERVICES AT THE BHSHC, EXCEPT THOSE ALLOWED BY CALIFORNIA MINOR CONSENT LAWS.

_____ _____
PRINT Name of Parent/Legal Guardian **Relationship to student**

_____ _____
SIGNATURE of Parent/Legal Guardian **Date**

BHS/B-TECH HEALTH CARE PROVIDER'S DISCLOSURE TO PATIENT OR PARENT/GUARDIAN ON IMMUNIZATION/TB RECORD SHARING WITH REGISTRIES

(Prepared pursuant to Health and Safety Code Section 120440)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gives them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, childcare, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- Patient's name, sex, and birth place
- Parents' or guardians' names
- Limited information to identify patients
- Details about a patient's shots/TB tests

Information entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you **DO want** your child's records in the registry, do nothing. You're all done.

If you **declined earlier and now you DO want** your child's records in the registry, please check the box below:

START SHARING

☐ **I ALLOW my/my child's immunization /TB test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry.**

If you DO NOT want the Berkeley High School/B-Tech Health Center to share your child's immunization/TB test information in the registry:

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry.** *Note: The immunization record may still be recorded in the registry for use by your physician's office. By law, public health officials can also look at the registry in the case of a public health emergency.*

If you have any questions, please call **(510) 644-6859**

Child's Name:_____ **Name of Parent/Guardian:**_____

Signature of Parent/Guardian: _____ **Date:** _____

Last updated 06/13

MEDICAL HISTORY - Berkeley High School/B-Tech Health Center

(This needs to be filled out and signed by the student's parent or guardian)

PLEASE ATTACH A COPY OF STUDENT'S IMMUNIZATION RECORDS

Student's name: _____ Birthdate: _____ Gender: M / F

Parent/Guardian's name: _____Relationship to student: _____

Address: _____

Phone: Home: _____Work: _____ Cell: _____

Emergency Contact (name/phone): _____

Health Insurance: _____

Name of primary medical provider: _____ Phone #: _____

We have no health insurance: ☐ We would like help obtaining insurance for this student: Yes ☐ No ☐

1. Is this student allergic to any medications? Yes ☐ No ☐ If yes, give name of medication and describe reaction:

_____

2. List any medication(s) student is taking now and the problem it is treating.

Medication: Dose: Reason:

_____ _____ _____

_____ _____ _____

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

4. Has student had any serious injuries? Yes ☐ No ☐ If yes, please give age at time of injury and describe the injury.

_____

Please check (√) whether **this student** has ever had any of the following health problems.

	Yes	No		Yes	No		Yes	No
Allergies……	☐	☐	Ear infections …….	☐	☐	Mononucleosis…….	☐	☐
Anemia…….	☐	☐	Fainting …….	☐	☐	Pneumonia……	☐	☐
Blood disorders……	☐	☐	Food allergy causing hives	☐	☐	Rheumatic fever……	☐	☐
Asthma ……	☐	☐	Migraines……	☐	☐	Scoliosis……	☐	☐
Bladder disease……	☐	☐	Hearing impairment ……	☐	☐	Seizures…… …	☐	☐
Kidney disease…….	☐	☐	Heart murmur……..	☐	☐	Sickle cell anemia	☐	☐
Blood clots/phlebitis……	☐	☐	Hernia…….	☐	☐	Thyroid disease……	☐	☐
Cancer……....	☐	☐	Hepatitis…….....	☐	☐	Tuberculosis……	☐	☐
Depression ……..…	☐	☐	High blood pressure……	☐	☐			
Diabetes ……..	☐	☐	High cholesterol……	☐	☐			
Chicken pox……	☐	☐	Mental Health Diagnosis	☐	☐			

Explain conditions checked ***yes*** above (age onset, treatment, current status, etc) :

_____

_____

Family health history: Have any of this student's blood relatives (parents, siblings, aunts, uncles, grandparents) living or deceased, had any of the following problems?

	Yes	No	Who		Yes	No	Who
Alcoholism…….	☐	☐	_____	Heart attack/stroke **after** age 55…	☐	☐	_____
Substance Abuse: type_____	☐	☐	_____	High blood pressure ……	☐	☐	_____
Allergies……..…….	☐	☐	_____	High cholesterol ……..	☐	☐	_____
Asthma……	☐	☐	_____	Lung disease…….……	☐	☐	_____
Birth defects ……..	☐	☐	_____	Mental health/Depression……..…	☐	☐	_____
Blood disorders ……	☐	☐	_____	Seizures……	☐	☐	_____
Cancer: type _____	☐	☐	_____	Smoking …….	☐	☐	_____
Diabetes ……	☐	☐	_____	Tuberculosis…….	☐	☐	_____
Heart attack/stroke **before** age 55	☐	☐	_____	Other: _____			

Parent/Guardian Signature: _____ **Date**_____

****************************DON"T FORGET TO ALSO SIGN THE PREVIOUS CONSENT PAGE***************************