Health, Housing & Community Services
BHS/BTA Health Centers

# WELCOME TO THE BERKELEY HIGH SCHOOL/BERKELEY TECHNOLOGY ACADEMY HEALTH CENTERS

We invite your student to take advantage of our free services offered at the Berkeley High School (BHS) and Berkeley Technology Academy (BTA) 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 BTA 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.**
- **An Immunization Registry Disclosure** informing parents that your child's Immunization Record is input into the California Immunization Registry. If you don't want your child's IZ information to be input in the registry, please sign and return this 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 BHS/BTA 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) Please attach your child's Immunization record to this packet. Immunization records given to the front office or the Athletic office may not make it to the Health Center for evaluation.

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

## BHS/BTA HEALTH CENTER SERVICES

**Medical**
- First Aid
- Family Planning and STI prevention, testing and treatment
- Immunizations and TB skin testing
- Assistance with referrals for primary care and insurance

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

**Mental Health**
- Crisis Intervention
- Individual Short Term Counseling
- Support Groups

**BHS/BTA Health Center**
**PARENT/LEGAL GUARDIAN CONSENT**

**Student Name:** _____ **Year of Graduation** _____ **Birthdate:** _____

I/We have read and understand the services offered at the BHS/BTA 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
- Short-term assistance with chronic illness management and referrals for ongoing care
- Immunizations (additional consents required)
- Prescription and over-the-counter medications
- Assistance obtaining health insurance
- Education relating to diet and weight control, drug and alcohol prevention, mental health, sexuality and pregnancy prevention, including abstinence
- Vision screening/referrals
- 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 <u>without parental consent:</u>**

- **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 BHS/BTA 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/BTA 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/BTA 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 FORM MUST BE SIGNED BEFORE YOUR CHILD CAN RECEIVE ANY SERVICES AT THE BHS/BTA HEALTH CENTER, EXCEPT THOSE ALLOWED BY CALIFORNIA MINOR CONSENT LAWS.**

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

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

Last updated 08/16

# MEDICAL HISTORY - BHS/BTA 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 / Trans

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

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Emergency Contact (name/phone): _____

Health Insurance (i.e. Blue Cross, Medi-Cal, etc.): _____

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 |
|---|---|---|---|---|---|---|---|---|
| Allergy needing Epi-Pen.. | ☐ | ☐ | Ear infections ..... | ☐ | ☐ | Mononucleosis..... | ☐ | ☐ |
| Anemia..... | ☐ | ☐ | Fainting ..... | ☐ | ☐ | Pneumonia..... | ☐ | ☐ |
| Blood disorders..... | ☐ | ☐ | Food allergy causing hives | ☐ | ☐ | Rheumatic fever..... | ☐ | ☐ |
| Asthma ..... | ☐ | ☐ | Migraines..... | ☐ | ☐ | Seasonal/Environmental | | |
| Bladder disease..... | ☐ | ☐ | Hearing impairment ..... | ☐ | ☐ | allergies..... | ☐ | ☐ |
| Kidney disease..... | ☐ | ☐ | Heart murmur..... | ☐ | ☐ | Scoliosis..... | ☐ | ☐ |
| Blood clots/phlebitis..... | ☐ | ☐ | Hernia..... | ☐ | ☐ | Seizures..... ... | ☐ | ☐ |
| Cancer..... | ☐ | ☐ | Hepatitis..... | ☐ | ☐ | Sickle cell anemia | ☐ | ☐ |
| Depression ..... | ☐ | ☐ | High blood pressure..... | ☐ | ☐ | Thyroid disease..... | ☐ | ☐ |
| Diabetes ..... | ☐ | ☐ | High cholesterol..... | ☐ | ☐ | Tuberculosis..... | ☐ | ☐ |
| 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**************************

*Last updated 08/16*

# BHS/BTA Health Center Permission to Share Your Child's School Immunization/Tuberculosis (TB) Screening Test Information with the California Immunization Registry (CAIR)

(Prepared pursuant to Health and Safety Code Section 120440)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you have may have TB infection and can be required for school entry. Keeping track of your child's shots/TB tests can be hard, especially if more than one doctor gave them. The California Immunization Registry (CAIR) is a secure computer system that doctors and authorized health care providers use to keep track of your child's shots and TB tests. If you change doctors, your new doctor can use the registry to see your child's shot/TB test record. CAIR is supported by the California Department of Public Health.

**How does CAIR help you?**

- Keeps track of all your child's shots and TB tests (skin tests/chest x-rays), so he/she doesn't miss any or get too many
- Gives you a copy of your child's most up-to-date shot/TB test record (from the doctor)
- Helps child care or school officials confirm that your child got shots/TB tests needed to start child care or school
- Helps your doctor send you reminders when your child needs shots

**How Does CAIR Help Your Health Care Team?**

Under California law, schools, child care, and other agencies may use CAIR only to:

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

**What information can be shared in CAIR?**

- Your child's name, sex, birth date, and birthplace
- Parents' or guardians' names
- Details about your child's shots/TB tests, such as type of vaccine/TB test and date given
- Limited non-medical information to correctly identify your child

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

**Parent and Guardian Rights**

It's your legal right to:

- Not to share your child's registry shot/TB test records with others besides your doctor or school
- Change your mind later if you want to stop or start sharing your child's shot/TB test information with other providers within CAIR
- Look at a copy of your child's shot/TB test record in CAIR and ask for corrections to any possible mistakes
- Know who has looked at your child's CAIR record

**If you DO want your child's records shared in the registry, you don't need to do anything. YOU'RE ALL DONE.**

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

**START SHARING**

☐ **I ALLOW 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/BTA Health Center to share your child's immunization/TB test information in the registry:

**DECLINE SHARING**

☐ **I DECLINE to allow 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:** _____