HealthPoint Family Care | Locations in Bellevue, Covington & Florence Extended Hours & Walk-ins

Enroll Today for the 2018/2019 School Year
Erlanger / Elsmere Schools

The HealthPoint School Based Health Centers (SBHC) are a safe and easily accessible place on school grounds where students can go for comprehensive preventive and primary health care services. The SBHC is staffed by a Nurse Practitioner and a School Nurse. The SBHC does not intend to replace your child's primary care provider but these services will help to address the gaps families may have accessing necessary healthcare.

HealthPoint Family Care is pleased to partner with Erlanger/Elsmere Schools to provide onsite healthcare to your children on the campus of Lloyd High School and Tichenor Middle School and at Howell, Lindeman and Miles Elementary Schools.
Enrollment in the school based health services is optional. You can enroll at any time during the school year by calling your school nurse. Please complete the attached paperwork and return to your school if you want to enroll today.

Before receiving services the following paperwork must be completed and turned in to the school. Please note that these forms are required to be updated annually. See the grey arrows ➡ for required signatures. Any incomplete forms will be returned to you.

- **Dental Enrollment Form – see ➡**
- **School Based Health Center Patient Profile – see ➡**
- **Health History form – see ➡**
- **Consent to Treat a Minor/HIPAA/Acknowledgement of Receipt on Notice of Privacy Practice. If you choose not to sign the Acknowledgement Of Receipt On Notice of Privacy Practice a HealthPoint Representative will contact you to see if you have questions – see ➡ for 2 required signatures**

Health Center Fees for Medical Visits:

- ➔ All **Uninsured patients** will be billed **$23** for their visit.
- ➔ All **Commercial patients** will be billed **$55** for their visit unless they have an Anthem, United Healthcare, Tricare or Humana plan that does not have a required PCP or with a HealthPoint Provider as the PCP and then HealthPoint will bill you for your cost sharing responsibility. There is an additional charge for immunizations for commercially insured patients.
- ➔ **Medicaid** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date.

Dental Center Fees- *dental only available at Tichenor Middle School and Lloyd High School Campus and Howell Elementary:*

- ➔ All **Uninsured patients** will be billed up to **$30** for each visit (with maximum fee of **$120** to complete all treatment and/or repair during the current school year).
- ➔ All patients with private dental insurance will be billed at the HealthPoint full fee schedule rate. **HealthPoint does not bill any private dental insurance.**
- ➔ **Medicaid** will be billed directly for Medicaid patients as long as Medicaid Card or Medicaid ID number is provided and active on the visit date. You may be billed for any patient responsibility.

The **School Based Health Center** can provide many services including:

- Well-child exams, school physicals, sport physicals
- Sick visits, prescriptions
- Immunizations –info at https://www.cdc.gov/vaccines/schedules/index.html and https://www.cdc.gov/vaccines/hcp/vis/index.html
- Over-the-counter medications (ie: Tylenol)
- Assistance in management of chronic illnesses
- Providing and/or connecting students with mental health services
- Vision screenings

The **School Based Dental Center** is only available at Howell, Tichenor and Lloyd and is staffed by a dentist and hygienist. Students from Miles, Arnett, and Lindeman can use the portable dentist office during school hours if the parent provides transportation. Many dental services are available in the school including:

- Comprehensive Exam
- Cleanings
- Fluoride and Sealant Treatments
- Most dental procedures performed in a dental office
- Over-the-counter medications (ie: Tylenol) for dental pain

If you have any questions, please contact your child's school. *Thank you for allowing us to serve you and your student.*

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Grade ____ Circle one: Lloyd Tichenor Howell Lindeman Miles Arnett

Student Name:_____ **Date of Birth:**_____ **Male / Female**

Address:_____ **Social Security #:**_____

City/Zip:_____ **Preferred Language:** English_____ Spanish _____

Other:_____

You agree we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Home Phone Number:_____ **Parent Cell Phone Number:**_____

Parent Work Phone:_____ ***Parent Email Address:**_____

** A "My Chart" account will be created for children age 0-11 if you provide an email address. A PIN number to activate your "My Chart" feature and instructions will be sent home in a sealed envelope with your student. For more information call 859-655-6104.*

Race: [ ] Asian [ ] Chinese [ ] Filipino [ ] Japanese [ ] White [ ] American Indian/Alaska Native [ ] Black/African America [ ] Other Pacific Islander [ ] Native Hawaiian [ ] Undetermined [ ] Other

Ethnicity: [ ] Hispanic [ ] Non-Hispanic **Your Relationship to Child:** [ ] Parent [ ] Foster Parent [ ] Legal Guardian

PARENT OR GUARDIAN INFORMATION:

Name:_____

Address:_____

City / Zip:_____

Please list your total household annual income

$ _____ # of People in Home _____

BILLING TO INFORMATION:

Check here [ ] if same as Parent/Guardian

Name:_____

Address:_____

City / Zip:_____

Income information is collected to support having health and dental programs in the schools. All district students are eligible.

I wish to enroll my child for: ☐ Medical Services ☐ Dental Services* ☐ Medical & Dental*

***Complete the Dental Enrollment Form for the next available appointment to be scheduled**

Medical Fees

- All patients who do not have Medicaid, Medicare or Private medical Insurance will be self-pay and will be billed $23 per medical visit at the school based health center. Vaccinations are included in the $23 visit copay.
- HealthPoint will bill Anthem, Aetna, United HealthCare, Tricare and Humana plans if there is no PCP or a HealthPoint Provider is selected as the PCP (preferred provider). Passport requires a HealhtPoint PCP in order to bill. You will be billed for your cost sharing responsibility.
- Any patient with private insurance except a plan above will be billed $55 per medical visit. Vaccines are an additional fee. No other private insurances are accepted or billed by HealthPoint.

Dental Fees

All patients who do not have Medicaid, Medicare or private dental insurance will be self-pay and will be billed up to $30 per dental visit at the school based dental center, with a maximum of $120 per school year (please see the cover letter for more details). Any patient with private dental insurance will be at the full dental fee rate, call 655-6104 for prices. **No private dental insurance is accepted.**

My child has (Check All That Apply):

NO insurance ☐

Private medical insurance ☐ *circle if:* **Anthem/UHC/Humana/Other** ID #:_____ Group #_____PCP:_____

Private dental insurance ☐ **PRIVATE DENTAL INSURANCE IS NOT ACCEPTED**

Medicaid ☐ *circle if:* **Wellcare, Aetna, Anthem, Humana, Passport ID # Required:**_____

A billing statement for private insurance, Medicaid (if payment required) and self-pay patients will be mailed to the billing information address above. Payment is expected in 20 days.

Consent to Treat A Minor Child

Completing this section will allow HealthPoint providers to examine and treat the minor child named below for simple illnesses or routine physicals including immunizations without a parent or guardian being present at the office or school health center.

Print Child's Name:_____ **Birth Date:**_____

I, _____, the parent/guardian of _____, give consent for ongoing assessment/evaluation/treatment of my child at HealthPoint offices, including school health centers. Evaluation and treatment of the child at the office will be done by a regular HealthPoint Provider. I give consent for the following dental, physical and/or mental health services to be performed at HealthPoint including school health centers:

- Assessment, diagnosis, evaluation, and treatment of the child even if a parent or guardian cannot be present
- Treatment of the child may include administration of any over-the-counter medications (e.g., pain relievers, cough suppressants, etc.) except the following: _____
- Routine lab work such as a strep screen or urine check.
- Routine immunizations as required by the State.
- Routine physicals, acute illness, follow ups
- Dental exam and procedures including x-rays, sealants, extractions, fillings, drilling, dental hygiene (amalgam or composite), and administration of local and topical anesthetic

The parent or guardian will be contacted for permission before additional things may be done. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

The following person(s) listed have my permission to bring/send my child to the school health center office for treatment:
The School Nurse, Teacher, School Administration and other school personnel may send my child for school based health services, or the parent or student, if age 18 or older, can contact HealthPoint or the school to schedule an appointment.

Others (Please Print Name / relationship to child):_____
_____ (Please initial) **I decline to give permission** for anyone to bring my child to the office for treatment except for school personnel. In a real emergency, as usual, the child will be treated as needed, even if the parent or guardian has not yet been reached for permission.

Release of Information

To promote continuity of care, I authorize HealthPoint Family Care to release a copy of records created at school based health visits to the primary care provider listed below and any other health care provider involved in the patient's care.

Primary Care Provider (PCP):_____ PCP Phone:_____

Authorizations

I certify the above information is correct. I hereby consent to treatment including whatever test or procedures may be directed by the medical or dental provider. I also consent to all state required immunizations. I authorize HealthPoint Family Care, Inc. to bill my insurance for services rendered. I further authorize the release of my medical and/or dental information to my insurers or responsible party. I understand that I will be responsible for all bills if there is not active Medicaid, Medicare or private insurance. I authorize HealthPoint to release health records to the school required for enrollment including school physicals and immunization records. I understand it is my responsibility to notify the school based health office about changes in guardianship, address, or phone number. A new form must be filled out for change in permission status for Treatment of a Minor Child. I understand that HealthPoint uses a single, shared medical record for all departments and offices and any treatment including substance disorder treatment is available to every HealthPoint provider caring for myself or my child for any reason.

Enrollment for the 2018/2019 School Year

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

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

Grade ____	Circle one:	Lloyd	Tichenor
Howell	Lindeman	Miles	Arnett

Please complete and return if you are enrolling your child for our school based dental program.
Available at Tichenor and Howell

Students at Lindeman, Miles, and Arnett must be transported by Parent/Guardian.

Please follow the instructions below – Initial Boxes to Sign Up for Services

Please read each option carefully and Initial boxes to tell us when and how to schedule appointments for your child. Only initial boxes where you would like to give consent. ☐

Be sure to sign below where you see the grey arrow to give permission for services.

_____

☐ *Schedule my child for the next available dental appointment –only for Howell, Tichenor & Lloyd students. Your child will receive a comprehensive exam, x-rays, a cleaning, and a treatment plan. After this initial exam and cleaning, your child will bring home the treatment plan with consent forms if any treatment is needed after the initial exam. A written summary will be sent home at each visit.* ***This will be considered your confirmation to schedule the initial visit and provide a comprehensive exam, x-rays, and cleaning.***

Special Note if your child goes to Miles, Arnett, or Lindeman -Call 655-6104 to schedule an appointment.

☐ *My child was treated at the school based health dental office during the 2017/2018 school year. Please schedule my child when they are due for their 6 month check-up for a cleaning, an exam, and x-rays. Your child will bring home the treatment plan with consent forms if any treatment is needed after the initial exam. A written summary will be sent home at each visit.* ***This will be considered your confirmation to schedule the initial visit and provide a comprehensive exam, x-rays, and cleaning.***

*Date of last dental visit:*_____

*Dentist Name:*_____

☐ *Enrollment for my child is for emergency treatment only. My child has a dentist and* ***I do not*** *want my child to have cleanings or routine exams and services at the school.*

☐ ***Initial here only if you want to be present for your child's dental treatment****. Appointments are available from 8:30 to 3:00 on scheduled days. If not checked then the initial visit will be scheduled at the first available appointment following your enrollment selection above at a date and time coordinated by the school to minimize disruption to your child's learning during school hours.*

☐ ***Initial here only if you give permission*** *In the absence of the dentist for the hygienist working under the supervision of the dentist assigned to the school to do a cleaning and oral health education at the school.*

☐ ***Initial here only if you give permission*** *for your child to receive over-the-counter medications (ie: Tylenol) for dental related pain.*

Print Patient/Student Name:_____ ***DOB:***_____

_____ _____

Parent/Guardian Signature ***Parent/Guardian Printed Name***

Patient Name:_____ Date of Birth:_____

Who is completing this form (print):_____ Signature:_____

Relationship to student: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Guardian [ ] Foster

I understand that it is my responsibility to notify the office about changes in health history.

History	Child	Mother	Father	brother/sister	Grandfather	Grandmother	History	Child	Mother	Father	brother/sister	Grandfather	Grandmother
Abnormal bleeding							Heart murmur						
Aids/HIV infection							Hepatitis						
Alcohol/drug abuse							High blood pressure						
Allergies							High cholesterol						
Anemia							Acid Reflux / Heartburn						
Anxiety							Immune System Problems						
Arteriosclerosis							Implant, prostheses, artificial joints						
Arthritis							Kidney trouble						
Artificial heart valves							Lead poisoning or exposure						
Asthma							Liver disease or Jaundice						
Back injury							Low blood pressure						
Blood or Bleeding disorder							Mitral-valve prolapsed (MVP)						
Bowel problems							Muscle problems						
Breathing problems							Painful swollen joints						
Bronchitis							Persistent cough						
Cancer or tumor							Persistent diarrhea						
Cough that produces blood							Persistent swollen glands in neck						
Damaged heart valves							Problems with mental health						
Depression							Recent weight loss						
Diabetes							Respiratory Problems						
Emotional problems							Rheumatic heart disease						
Emphysema							Sexually transmitted disease						
Epilepsy or Seizures							Sinus trouble						
Fainting Spells							Skin problems						
Gallbaldder or stones							Stomach problems						
Hay fever							Stomach ulcer						
Hearing or speech problem							Stroke						
Heart attack							Thyroid problems						
Heart disease or problems							Tuberculosis						
Other:							Vision problems						
Other:							Other:						

Is your child pregnant or nursing?] Yes] No	Does your child wear contact lenses? [ ] Yes [ ] No
Is your child allergic to any medications? Yes No	Does your child have environmental or food allergies? Yes No
Allergy:	Reaction:

What are your child's main health concerns:

What are your child's main dental concerns:

HealthPoint's risk assessment is a tool for our providers to partner with you to promote a healthy lifestyle for your child!

Surgeries and Hospitalizations in last 5 years: Check if None [ ] PE tubes [ ] Radiation Treatment [ ] Tonsillectomy [ ] Oral / IV bisphosphonates [ ] Valve Replacement Other:	Child's Grade in School?_____ # days absent this year?_____ How are they doing in school? [ ] doing well or [ ] doing poor Does the child live in a home built before 1970? [ ] Yes [ ] No Does anyone in the home smoke? [ ] Yes [ ] No Who smokes in home? [ ] Mother [ ] Father [ ] Sibling [ ] Other Is there a gun in the home? [ ] Yes [ ] No Any concerns about alcohol or drugs? [ ] Yes [ ] No
Does your child use tobacco: [ ] Yes [ ] No if "yes" [ ] Cigarettes [ ]Smokeless Amount: ____ pack(s)/can(s) per [ ] day or [ ] week How many years?	Has the child been physically abused? [ ] Yes [ ] No Has the child been sexually abused? [ ] Yes [ ] No Other concerns:
Preferred Pharmacy: Pharmacy phone number: Pharmacy city: **Prescriptions are sent electronically to the pharmacy**	Primary Care Physician: HealthPoint ☐ Name of physician or group: Phone number: Date of last physical:
Specialists Caring for Your Child: Check if None ☐	Name of Dentist: Dentist phone number: Date of last dental exam:

Current Medications Prescription, herbal or Over the counter — **Check if no current medicines** ☐	**Instructions (1 time a day, 2 times a day)**	**Dose (# mg, mg/mm or unit)**

Child's parents are: [ ] Married [ ] Separated [ ] Divorced [ ] Other

Who's the primary Caregiver for this child: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Other

What are custody arrangements?

Immediate Family Name:	**Age**	**Current Health?**	**Lives With Child?**
Mother		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Father		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Guardian		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Sibling		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Sibling		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Sibling		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no
Sibling		[ ] living [ ] sick [ ] deceased	[ ]yes [ ]no

To Avert Serious Harm: We may disclose your PHI when necessary to prevent a serious threat to the safety and health of the public or a person, including yourself.

Government Functions: We may disclose your PHI to military officials if you are an active member of the military or to determine eligibility and/or benefits for veterans. We may also disclose your PHI for national security, intelligence activities, the protection of the President, and to determine officials' suitability to serve in public office. If you are an inmate of a correctional facility, we may disclose your PHI to officials at the correctional facility.

Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws or similar programs that provide benefits for work related injuries or illness.

Other Permitted and Required Uses and Disclosures

Other uses and disclosures not described on this notice will be made only with your authorization or opportunity to object unless required by law. These include most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures for marketing purposes, and disclosures that constitute a sale of your PHI. You may take back any authorization you agreed to, at any time, in writing.

2. Your Rights

The following are statements of your rights about PHI.

You have the right to inspect and request a copy of your PHI. Federal law, however, does create some exceptions to this right and exempts the following records: psychotherapy notes; information gathered to be used in a civil, criminal, or administrative action or proceeding. In certain circumstances we may deny your request and you may be entitled to request that our denial be reviewed.

You have the right to request a restriction of your PHI. This means you may ask us not to use or share any part of your PHI for the purposes of Treatment, Payment or health care Operations. You may also request that any part of your PHI not be disclosed to family members, friends or other individuals who may be involved in your care. While HPFC will consider any reasonable request for restrictions, we are not required to agree to your request, unless you request a restriction on certain disclosures of your PHI to a health plan where you have paid for the service on your own.

You have the right to request that PHI about you be communicated to you in a confidential manner, such as sending mail to an address other than your home or by other means. Your request must state how or where you would like to be contacted, and we will accommodate reasonable requests.

You have the right to obtain a paper copy of this notice from us upon request at any time. You may ask us to give you a paper copy of this notice at any time. You may also obtain a copy of this notice on our website, http://www.healthpointfc.org.

You may have the right to request that HPFC amend your PHI. To request that HPFC amend you PHI, you must make your request in writing and explain why the amendment is needed. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare an answer to your statement and will provide you with a copy of any such answer.

You have the right to receive an accounting of certain disclosures, if any, of your PHI. The accounting of disclosures does not apply to disclosure for treatment, payment and health care operations or for disclosures we have made to you or at your request. The first accounting requested in a twelve (12) month period is free, but you may be charged for the cost of producing additional accountings during that same twelve (12) month time period.

You have the right to or will receive notifications of breaches of your unsecured PHI. If your PHI maintained by HPFC or its business associates has been breached, HPFC will notify you of the situation and take actions to mitigate any harm that might results from the breach.

You have the right to complain to HPFC or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by HPFC. You may file a complaint with us by notifying our HIPAA Privacy Officer at the address or phone number below. Filing a complaint will not affect your health care services in any way.

TO EXERCISE ANY OF THESE RIGHTS, you may ask any staff member in the HealthPoint Family Care offices for the proper forms and instructions.

We reserve the right to change the terms of this notice for all records and will inform you by posting the revised notice in the waiting area and on our website, http://www.healthpointfc.org.

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and notify you following a breach of your unsecured PHI. If you have any questions or complaints, please contact our HPFC Privacy Officer at:

HealthPoint Family Care
1401 Madison Avenue
Covington, Kentucky 41011
859-655-6100.

This notice was published and becomes effective on July 1, 2013.

HealthPoint Family Care

HIPAA 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.

This Notice of Privacy Practices describes how HealthPoint Family Care ("HPFC") may use and share your medical information with others to carry out Treatment, Payment or health care Operations and for other purposes that are permitted or required by law. It also describes your rights to see and amend your Protected Health Information ("PHI"). PHI is information about you and services you have received. This would include information such as your name, address, date of birth, diagnosis, treatment, or other information that may identify you and your past, present or future physical or mental health or treatment you receive.

1. Uses and Disclosures of Your Medical Information

Your PHI may be used and shared by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of HPFC, and any other use permitted or required by law.

Treatment: We will use and share your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (for example, sending PHI about you to a specialist as part of a referral).

Payment: Your PHI will be used, as needed, to receive payment for your health care services. For example, getting approval for a hospital stay may require that your PHI be shared with the health plan to obtain approval for the hospital admission. Or for example, sending billing information to your insurance company, Medicaid or Medicare.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of HPFC. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, health oversight audits or inspections, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders: We may use and disclose your PHI to contact you to remind you of your appointment by phone or email.

Treatment Alternatives: We may use and disclose your PHI to inform you about possible treatment options and health related benefits and services that may be of interest to you.

Fundraising: We may use and disclose your PHI to contact you in fundraising efforts for HPFC and, in the event you prefer to not receive such communications, you are able to opt out of receiving them.

Uses and Disclosures Without Your Authorization

We may use or disclose your PHI in several other situations **without** your authorization. We may give out PHI about you for public health purposes, abuse or neglect reporting, research studies, funeral arrangements and organ donation, workers' compensation purposes, Food and Drug Administration requirements, and emergencies. We also disclose PHI when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

As Required by Law: We may disclose your PHI when required to do so under federal state or local law.

For Public Health Activities: We may disclose your PHI for certain public health activities such as prevention

Abuse and Neglect: We may disclose your PHI to public officials who are authorized by law to receive reports regarding abuse, neglect and domestic violence.

Health Oversight Activities: We may disclose your PHI to organizations providing oversight of health care facilities and services, such as governmental agencies and benefit programs.

For Legal Proceedings: We may disclose your PHI in the course of judicial or administrative proceedings, including in response to a subpoena or an order of the court.

For Law Enforcement Purposes: We may disclose your PHI to law enforcement officers in certain circumstances where we suspect criminal misconduct or to report a crime on our premises or in emergency situations.

To Coroners and For Organ Donation: We may disclose your PHI to coroners or medical examiners for the purpose of identifying a deceased person, determine the cause of death or as otherwise required. We may also disclose your PHI to funeral directors as necessary for them to carry out their duties.

For Research: We may disclose your PHI to researchers if an institutional review board has approved such disclosures because adequate safeguards have been taken to ensure the protection of your PHI

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Vaccine Resources Acknowledgement

If you wish to receive more information regarding required and recommended vaccines you may contact HealthPoint directly by calling 859-655-6104 or visit the website of the Centers for Disease Control and Prevention (CDC) at www.CDC.gov.

You may view or print an immunization schedule to be aware of which vaccines your child should receive from ages 0-18 as well as recommended adult vaccines by visiting https://www.cdc.gov/vaccines/schedules/index.html.
The CDC also provides Vaccine Information Statements (VISs) which are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to vaccine recipients. You may view or print the most current VISs at https://www.cdc.gov/vaccines/hcp/vis/index.html.

Authorizations

Federal law requires that healthcare staff provide or advise how to download or view a copy of Vaccine Information Statements to a patient, parent, or legal representative before each vaccine and before each dose of specific vaccines if more than one dose in series.

I acknowledge by signing below that I have been made aware of where to obtain vaccine resources and the most recent Vaccine Information Statements prior to my child (or myself if over 18) being administered vaccines in the school based health clinic.

Signature of Parent/Guardian:_____ Print Name__ _____Date_____

ERLANGER/ELSMERE SCHOOLS

THE ERLANGER ELSMERE SCHOOL DISTRICT
CONSENT TO SHARE INFORMATION
WITH AN OUTSIDE AGENCY OR PERSON

_____ Date of Birth:_____
Student Name

_____ Phone:_____
Street Address

_____
City, State, Zip Code

X **I hereby authorize the Erlanger Elsmere School District to communicate/share information with the following individual or agency. I understand that the information that may be shared may be protected by HIPAA as a protected health record or by FERPA as a confidential educational record. This information is being shared for the purpose of two way communication for exchange of information for treatment planning and progress.**

S **Health and Safety**

HealthPoint Family Care
Name of Individual or Agency
1401 Madison Avenue
Street Address
Covington, KY 41011
City, State, Zip Code

I understand that this authorization for release/invitation is voluntary and that I may revoke it at any time by my written notice. Unless revoked by me, and in writing, this authorization for release/invitation shall be in full effect until. If no date is listed, this release shall be in effect for one (1) calendar year from the date signed. Any revocation will have no effect on prior disclosures granted in accordance with and in reliance upon this authorization for release/invitation. I understand that information disclosed by my authorization may be re-disclosed by this agency or individual only through the process set out in the Family Educational Rights and Privacy Act (FERPA).

_____ _____
Signature of Parent/Legal Guardian
(Student must sign if over 18 years of age)
Date

_____ _____
Signature of Witness
Date

Please Fax a copy of this completed form to Shawn Neace at (859) 727-5653
500 Graves Avenue, Erlanger, Kentucky 41018