



Benzie-Leelanau District Health Department

School-Based Nursing Program (SBNP)

Parent/Guardian Consent

Student Name _____ Birthdate _____/_____/_____

Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor child for nursing care provided by the **Benzie-Leelanau District Health Department School-Based Nursing Program (SBNP)**. Students without a signed parent/ guardian consent will not be seen, except for a student’s first visit to the school-based nurse, when staff will call the parent/ guardian before providing any services, for a one-time-only verbal consent.

Services not provided include prescribing medications, dispensing birth control, provision of abortion counseling or referrals, and dispensing of medications other than those covered under standing orders. Family planning drugs and/or devices will not be prescribed, dispensed, or distributed and no abortion counseling, referrals, or services will be provided.

Consent for services

SBNP services can include nursing screenings; assessment and care; emergency care; minor injury treatment; medication administration; coordination of chronic disease management in partnership with the school and primary care provider; immunizations assessment; referrals to establish primary care, oral health care, and other care needs; and nursing assessment of risk behaviors. In communication with parents/guardians, the SBNP nurse may administer over the counter medications including but not limited to ibuprofen, acetaminophen and loratadine in accordance with established protocols developed by the **Benzie-Leelanau District Health Department Medical Director for the SBNP**.

I have reviewed and understand the services offered by the SBNP.

I understand that testing for blood borne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent if a healthcare professional receives a cut or exposure to blood or body fluids.

I have been given or have had the opportunity to review the **BLDHD Privacy Notice (attached)**.

I understand that all medications to be administered by school staff or are self-carried by the student require the **Medication Administration Authorization Form** to be completed by the Parent & Physician prior to administration. All medications must be in the original, properly labeled container & dispensed by a physician/pharmacist or be in the original over the counter packaging.

I further consent to release of information to my child’s primary/specialist care provider with the school personnel regarding follow-up care for assessment/treatment provided, coordination of care, or school services.

I give consent for my student to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I will update the student health information annually as warranted by changes in medical condition. I understand that I may withdraw my consent at any time during the school year by contacting the health office.

I verify that I am authorized to sign consent for the person named in this document

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date _____

Mother/Guardian _____

Home # _____ Work # _____ Cell # _____

Father/Guardian _____

Home # _____ Work # _____ Cell # _____

EMERGENCY CONTACT INFORMATION – Someone other than parent(s) above.

Name (print): _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

The Benzie-Leelanau District Health Department occasionally uses photographs of students and school nurses in our presentations to promote our School Wellness Program to community members and funding partners. Photographs may be used in brochures, posters, newspaper articles, power point presentations, and as part of our annual report to the school community. I grant Benzie-Leelanau District Health Department and its respective agents, employees, officers, and representatives the right, but not the obligation to incorporate or use still photograph(s) in any manner the SBNP sees fit.

Yes, I give consent for photos (Initial) _____ No, I don't give consent for photos(Initial) _____

Benzie-Leelanau District Health Department

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Our Privacy Commitment to You We care about your privacy. The information we collect about you is private. We are required to maintain the privacy and security of your Protected Health Information, provide you with a copy of our privacy practices, and follow the duties and privacy practices required by law. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Only people who have both the need and the legal right may see your information. With your written permission we will disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so. We may contact you to provide appointment reminders or to share information about other health services.

Treatment We may disclose medical information about you to coordinate your health care. For example, between your counselor and physician.

Payment We may use and disclose information so the care you get can be properly billed and paid. For example, sending billing information to a health insurance plan.

Business Operations We may need to use and disclose information for our business operations. For example, we may use information to review the quality of care you receive.

Exceptions For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.

As Required by Law We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, or to avert a serious threat to health or safety or in other kinds of emergencies.

With Your Permission If you give us permission in writing, we may use and disclose your personal information. If you give us permission, you have the right to change your mind and revoke it. This must also be in writing. We cannot take back any uses or disclosures already made with your permission prior to revoking the release.

Your Privacy Rights You have the following rights regarding the health information that we have about you. Your requests must be made in writing to Benzie-Leelanau District Health Department. There are limitations to receiving copies of the records.

Your Right to Inspect and Copy In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.

Your Right to Amend You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for denial.

Your Right to a List of Disclosures You have the right to ask for a list of disclosures of Protected Health Information made for purposes other than treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

Your Right to Request Restrictions on Our Use or Disclosure of Information

You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to such requests.

Your Right to Request Confidential Communications You have the right to ask that we share information with you in a certain way or in a certain place, such as asking us to send information to your work address instead of your home address. You do not have to explain the basis for your request. We will accommodate reasonable requests.

Complaints and Communications to Us If you want to exercise your right under this notice or if you wish to communicate with us about privacy issues or if you wish to file a complaint, you can contact: Privacy Officer, Benzie-Leelanau District Health Department, 6051 Frankfort Hwy Ste 100, Benzonia, MI 49616.

Complaints to the Federal Government If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. Office of Civil Rights, Dept. of Health and Human Services, 200 Independence Avenue. S.W. Washington, D.C. 20201.

Benzie-Leelanau District Health Department

Notice of Privacy Practices (Family copy)

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Our Privacy Commitment to You We care about your privacy. The information we collect about you is private. We are required to maintain the privacy and security of your Protected Health Information, provide you with a copy of our privacy practices, and follow the duties and privacy practices required by law. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Only people who have both the need and the legal right may see your information. With your written permission we will disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so. We may contact you to provide appointment reminders or to share information about other health services.

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