We are working hard to slow the spread of COVID-19 and mitigate the impact of the coronavirus outbreak for our members, staff, and community. Most cases of COVID-19 are mild and can be managed at home. For students who need care or advice, we are always here to help with virtual options and in-person care.

Many necessary changes are being implemented across all of Kaiser Permanente. Some of these changes are temporary, with health and safety as our top priority.

Virtual and In-Person Care

- Patients with essential care needs can still receive in-person care by appointment.
- In-person care will be available at the following KPWA SBHC sites by appointment only:
  Aki Kurose, Interagency, and Nathan Hale. All SPS students can receive care.
- To serve the best interest of our members, patients, and community, we are evolving the way we deliver care. We are leading within Washington as one of the first health care organizations to deliver the majority of care virtually.
- We will continue to provide excellent care for students through our broad array of virtual care options and in-person care when needed. Allowing students to stay home and still get great care will help address the community spread of COVID-19.
- Virtual care* gives you convenient and safe ways to get high-quality care from Kaiser Permanente without leaving home. Options include:
  - Phone appointments
  - Video visits
- We are reaching out to patients whose care was postponed due to COVID-19 to make sure they are getting the care they need. Patients scheduled for in-person care will be given information about our face mask guidelines and check-in process. If you have cold or flu symptoms, please let us know before you come in for your appointment.

Face masks

- To help ensure your safety and the safety of others, all members will be asked to wear a face mask. You can wear your own mask, or we can provide you with a disposable mask when you enter the building. Please wear the mask for your entire visit unless you are medically not able to or you are specifically told otherwise by a health care professional.

Visitors

- To limit the number of people in our facilities, we are asking patients to come alone to in-person appointments. We understand that at times coming alone may not be possible due to childcare needs or other issues.
Franklin Teen Health Center

Hours: Weekdays, 9:00 am - 4:00 pm

We are providing telephone visits, video visits, and in-person care for students. Call 206 381 4182 to connect to our staff.

What kinds of services are offered?

**Primary Care**
- Sports physicals
- Vaccines
- Check ups: physical exams
- Acne and eczema
- Allergies and asthma
- Women’s health care

**Mental Health**
- Feeling blue
- Stress and depression
- Relationships problems
- Self-esteem
- Family conflict
- Peer pressure
- Healthy habits

**Health Education**
- Growth and development
- Nutrition
- Healthy relationships
- Sexual health and education
- Tobacco and drug abuse prevention

Referrals to community resources—including health insurance, drug and alcohol treatment, mental health care, and chronic illness care—are also available.

**Our Staff**
Health Educator  
School Nurses  
Nurse Practitioners  
Physician Assistants  
Mental Health Counselors

**Who can be seen?**
Students may be seen by appointment with consent from their parents, during school hours or after school. Teens of any age may be seen for confidential reproductive health care services (birth control, exams). Mental health services are available without parent consent for teens age 13 and over [Reproductive Privacy Act, RCW (9.02)].

The School-Based Health Centers are sponsored by Kaiser Permanente in partnership with Public Health—Seattle and King County. School-based health centers are provided in part by the voters of Seattle through the Families and Educational Levy.
School-Based Health Centers
Consent for Health Services

School-Based Health Centers located in Seattle Public Schools must have a signed consent from a parent or legal guardian before providing services to youth, except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent. Youth may independently access reproductive health care at any age; they may independently receive drug and alcohol services and mental health counseling from age thirteen. If necessary, the Centers will inform youth of options for outside care and will assist the youth in discussing these issues with parents/guardians. If the youth is enrolled in school but is not enrolled in a School-Based Health Center, he/she can continue to receive school nurse services.

I hereby request and authorize that:

Print Youth’s Name: ________________________________________________       _______________
First Name              Middle Initial                   Last Name                    Birthdate

receive any and all health care services available from and deemed necessary by the staff of the SBHC. These services may include, but are not limited to, such procedures as well-teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and X-rays. Consent is also given for referral of care and if needed, emergency transportation, to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Center and its staff. This authorization does not allow services to be rendered without the youth’s consent, unless she/he is unable to consent.

When consent is provided for care, all information is kept confidential except in the following circumstances:
1. The client gives permission through a signed release of information.
2. If he/she indicates risk of imminent harm to self or others.
3. He/she has a life threatening health problem and is under 18 years old.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.
6. Certain non-protected information such as yearly physicals and immunizations and general information regarding the healthcare you receive at the School-Based Clinic may be included in your medical record and/or shared with your primary care provider. No confidential information will be shared without the students consent.

I understand the youth’s consent is legally required for release of information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted diseases (including HIV/AIDS testing), and alcohol and drug or mental health counseling.

The School-Based Health Center encourages each youth to involve his/her parents or guardians in health care decisions whenever possible.

Consent for services is authorized for the length of time the youth is enrolled in a school with a SBHC. I may choose to withdraw the consent at any time by writing to the Center that serves the youth.

Youth Signature: _______________________________________________Date: ____________

Parent/Guardian Signature: _____________________________________Date: ____________

Name/Relationship of Legally Responsible Guardian (Print):______________________________

Parent/Guardian Address:_________________________________________________________

Parent/Guardian Email Address:___________________________________________________

Telephone: (_____)__________________ Work Telephone: (______)_______________________
School-Based Health Center Registration Form

Please help us serve you better and comply with our reporting requirements by providing the following confidential information.

Student's Name: ___________________________________________________________________________________

Last                 First       Middle    Preferred
 Female   Male   Trans*/Gender Non-Conforming

Student's School ID: ____________________   Birth Date: ___________________    Social Security #:______________________  (optional)

Student's Address:  ____________________________________________________  Street   City   State    Zip

Student's Cell:_______________________  Contact Name:__________________________________  Phone:  ________________  Relationship to Student: _____________

Is the student Spanish/Hispanic/Latino?   Yes   No

Which of the following best describes the student's race?  (Check One)
 African American/African Native   American Indian/Alaskan Native   Asian
 Pacific Islander   White   Multi-Racial

Supplemental Information
Who referred the student to the clinic?:   __________________________________         Student's Grade?:  _________________

Does the student have a doctor?   Yes   No

If yes, please provide name and phone number

Does the student have permanent place to live?   Yes   No

What is the student’s preferred language: ________________________    Family Language:  _____________________________

Is the student eligible for the Free or Reduced Lunch Program?   Yes   No   Don’t Know

List activities in which the student is involved:   __________________________________________________________________

Medical / Mental Health History
Does the student have any medical problems or mental health concerns? _____________________________________________

Does the student need medications on a regular basis?  _______________ What?______________________________________

Has the student ever had any surgery, serious illness, or injury? _____________________________________________________

Does the student have allergies to any medications?  _____________________________________________________________

Has anyone in the student's family had the following (Check all that apply)
 asthma   diabetes   heart problems/stroke   mental health problems   alcohol or chemical use
 cancer   seizures   high blood pressure   high cholesterol   died before age 50

Insurance Information
You can support the Health Center by providing your insurance or Medicaid information. Completion of the information below is required so that we can bill your insurance company, if applicable. No one will be denied services due to inability to provide this information.

Is the student insured?   Yes   No Insurance   Don’t Know

Plan Type:   Medicaid/Healthy Options   Basic Health Plan   Private/Commercial   Group Health

Insurance Company:_____________________________  Plan Name:  _____________________________

Policy Holder’s Name:__________________________________  Policy Holder’s Social Security #:______________________  (optional)

Group Number or Medicaid Number:  _____________________________

Consent to Release Information to Insurance Carrier: I certify the information supplied above is accurate. I authorize release of medical and related information to my health insurance company or other third party payor for the purpose of obtaining payment for services rendered. Policies are in place to assure privacy is maintained related to confidential services.

Signature: ________________________  Date:  ________________  Relationship to Student:  _____________

Revised 8/11/17

Please complete both sides
## Community Based Organization
### Parent/Guardian Consent Form
#### 2020-2021 Approval

Public Health – Seattle & King County
School-Based Partnerships Program
401 5th Ave #1000
Seattle, WA 98104
206.263.8350

Franklin Teen Health Center
Kaiser Permanente
3013 S Mt Baker Blvd
Seattle, WA 98144
206.326.2750

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**Consent to Release of Education Records Under the Family Education Rights and Privacy Act (FERPA)**

I consent to the release of my child’s education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

1. Student name, DOB and contact information
2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
3. Attendance History
4. Discipline History
5. Coursework and grades History
6. Test Scores History
7. Enrollment History
8. Assignment Grades
9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child’s academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child’s school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health - Seattle & King County, Kaiser Permanente staff will work with my child and/or his/her school in an effort to improve my child’s success at school. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District’s School & Community Partnership Department, MS: 33-160 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2021. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

<table>
<thead>
<tr>
<th>Parent/Guardian Signature (if youth is 17 or younger):</th>
<th>__________________________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Printed Name:</td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>Student’s Signature (if youth is 18 or older):</td>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>Today’s Date:</td>
<td>__________________________________________________________________________</td>
</tr>
</tbody>
</table>

PRINT **Student’s Name** (First and Last name)  

**Student School District ID #**  

**Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student’s school**

For more information please refer to [www.seattlepublicschools.org/communitypartnerships](http://www.seattlepublicschools.org/communitypartnerships)  
20-21 Consent