



Parent / Guardian Packet

Health Services Information and Required Forms for Youth Program Participant



Accredited by Accreditation Association for Ambulatory Health Care, Inc.



TO PARENTS / GUARDIANS OF YOUTH PROGRAM PARTICIPANTS – For 2017

Watkins Health Services (WHS) is the student medical clinic on the Lawrence Campus of the University of Kansas. Occasionally, participants in youth programs/camps (i.e. “campers”) are brought to WHS for medical needs and we want to assure you that WHS will provide these campers with the same high quality care that KU students receive. All of our healthcare providers are board certified and many of our staff members are also parents. We understand the needs of campers and the concerns of parents! That is why if a camper comes to WHS for care, we will contact the parent or guardian as soon as possible (in compliance with the laws of Kansas).

While we are not an Emergency Room, we do stabilize and transfer patients when that is needed. Most of the time, we merely address the immediate issue and refer the patient back to their family physician for follow-up care.

We do recommend that you complete this packet of forms and submit it back to the Youth Program Director. In the unlikely event that your camper requires medical care during the program/camp, the forms will be brought to WHS to provide our staff important information about the camper’s health conditions as well as emergency contact information in order to facilitate care.

Please understand, there are charges for office visits as well as for any services ordered such as lab tests, X-rays, medications, etc. **If any charges are to be billed to an insurance company, a copy of the participant’s insurance card(s) must also be provided during the initial visit.** PLEASE NOTE: We do not bill Medicare, Medicaid, KanCare, etc. as WHS is not a participating provider with these or similar government programs. Those charges would become the parent’s/guardian’s responsibility as noted on the enclosed Treatment Agreement.

If your camper is bringing any personal medication or medical device to campus, please be sure that:

- 1) The camper fully understands how and when to take the medication or use the device;
- 2) The device or any remaining doses of the medication return home with the camper at the end of the program.

For more information about the services and healthcare providers at WHS, please visit our website: www.studenthealth.ku.edu

If we can be of further assistance or answer any questions about this packet, please feel free to contact our Business Office at 785.864.9520.

YOUTH PROGRAM PARTICIPANT'S HEALTH HISTORY FORM

This completed form must accompany the individual on first visit to Watkins Health Services (WHS).
It is essential that our Treatment Agreement is signed by a parent or guardian.

Name of Program / Camp: _____

Name & Contact Information for Program's Director: _____

Youth's Name _____ Birth Date _____ Sex _____
Last First Middle

Parent Name _____ Best Phone # to call _____

Address _____
Street City, State Zip

Emergency Contact, if other than above: Name _____ Best Phone # to call _____

Relationship to Youth _____

Name of Family Physician _____ Phone # _____

1. Does the youth have any significant illness or disability? NO YES If yes, please explain _____

2. Please check if the youth has or has had any of the following health conditions:

- Asthma Mental health Dizziness/fainting Diabetes Epilepsy/seizures Kidney problems
 Gastrointestinal problems Cardiac Headaches Other _____

3. Has the youth had any other significant illnesses, injuries, or surgeries? NO YES If yes, please explain _____

4. Medications and their dosages taken by the youth

Name of Medication	Dosage	Frequency	Reason Taken

5. Immunization History – Please provide DATES for the following OR provide a copy of an Official Immunization Record

Last Tetanus (Tdap) booster: _____ (should be updated no longer than every 10 years)

DTaP 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

MMR 1st _____ 2nd _____

Polio 1st _____ 2nd _____

Meningococcal conjugate vaccine (MCV) _____

Hepatitis A 1st _____ 2nd _____

Hepatitis B 1st _____ 2nd _____ 3rd _____

Chicken Pox (Varicella) 1st _____ 2nd _____

TB skin test – Date of Negative Result _____ OR Positive Result _____

6. Is the youth allergic to any medications? NO YES If Yes, please list _____

7. Does the youth have any other allergies? NO YES If Yes, please list _____

8. Do any allergies require an EPI Pen to accompany camper? NO YES If Yes, please list _____

If necessary, please attach additional health information.

**TREATMENT AGREEMENT FOR YOUTH PROGRAM PARTICIPANT
WATKINS HEALTH SERVICES (WHS) AT THE UNIVERSITY OF KANSAS**

I acknowledge that I am the parent or guardian of the youth participating in a KU program/camp and that I am authorized to sign this document on behalf of the youth. I understand that if my camper requires healthcare services at WHS, I will be notified as soon as possible as to the type of care necessary in keeping with the laws of Kansas. I understand that WHS is not an Emergency Room but that they will stabilize and transfer all urgent and emergent conditions. I also acknowledge that if urgent/emergent care is needed, it may not be possible to notify me in advance of such care but that I will subsequently be contacted as soon as possible.

CONSENT TO TREATMENT

1. I hereby consent to such health care as may be deemed necessary by the WHS providers including x-ray examination, lab tests, administration of medications, and any other diagnostic or therapeutic treatments.
2. I understand if an initial lab test indicates there is a need for additional testing, I will be contacted and encouraged to follow-up with our primary care provider. The WHS provider will explain when these tests may be needed.

GENERAL CONDITIONS FOR TREATMENT BY WHS

3. I understand that WHS is not responsible for loss or damage to clothing, jewelry or other valuables in my camper's possession.
4. I acknowledge that the use of any video capturing devices (cameras, cell phones, etc.) by other than authorized personnel for official business is prohibited.
5. I will be respectful of all the healthcare providers and staff in WHS, as well as other patients.
6. I understand that upon my request, WHS will send a copy of the medical record to our primary care provider.

INSURANCE ASSIGNMENT

7. I hereby assign all benefits payable under the terms of my insurance policy/healthcare coverage to WHS, and I authorize payment directly to WHS for any claim filed on behalf of the person for whom I am duly authorized to sign for insurance benefits.
8. I hereby authorize WHS to disclose to my health insurance carrier information from this youth's medical record as needed in presenting claims for benefits.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

9. I understand that **WHS does not contract with all insurance companies** and it is my responsibility to know if my insurance plan provides coverage for WHS services or requires a referral or pre-approval for such services.
10. **Further, I understand that WHS is not a contracting provider for and cannot bill Medicare or any Medicaid program.** If I have these types of government healthcare benefits, I am responsible for paying all WHS charges and it is my responsibility to seek reimbursement from these programs. *This is the healthcare coverage for my youth program participant:

Insurance Company _____

Claim Form Address _____

Member I.D. # _____ Group # _____ Name of Policyholder _____

Policyholder Date of Birth _____ Address of Policyholder _____

11. I understand that I am financially responsible to WHS for any charges, co-pays and deductibles not covered by my insurance company. And, I understand that if I do not pay my bill within three billing cycles of the date of service, the overdue account will be sent to a collection agency. If I am the parent or legal guardian of the patient, I acknowledge that I will be financially responsible for unpaid charges.
12. If I do not want my insurance company/health plan billed or a statement sent for charges, it is my obligation to immediately advise the WHS Business Office. I understand that I may address any questions concerning my charges, coverage, billing or payments, to the WHS Business Office at: 785.864.9520

***PLEASE ATTACH A COPY (both front and back) OF THE HEALTH INSURANCE CARD FOR THIS PARTICIPANT!**

Print Name of Youth Program Participant

Date

Signature (Parent, Guardian or Representative)

Relationship to Participant

Print Name of Parent, Guardian or Representative

Phone number for Parent, Guardian or Representative

**CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

In our Notice of Privacy Practices (NPP) we provide you information about how Watkins Health Services can use or disclose your youth program participant's medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent. It is available online:
https://studenthealth.ku.edu/sites/studenthealth.ku.edu/files/docs/Notice_of_Privacy_Practice.pdf

Or you may call and request that one be sent to you: 785.864.9507

By signing this Consent form, you:

- (1) Acknowledge that a copy of the NPP has been provided or offered to you; and
- (2) Consent to our use and disclosure of your participant's health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed any health information in reliance upon this Consent.

Print Name of Youth Program Participant

Date

Signature (Parent, Guardian or Representative)

Relationship to Participant

Print Name of Parent, Guardian or Representative

Phone number for Parent, Guardian or Representative

NOTE to Parents / Guardians: This is our standard Notice and is for your information only. You do not need to return this to the Program/Camp Director.

———— 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 READ IT CAREFULLY.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get a copy of your medical record and other health information we have about you. Check with us to see if we have electronic or paper versions available. We will provide a copy or a summary of your health information within 10 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record — You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications — You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share — You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared your information — You can ask for a list (an accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as for public health purposes). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you — If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated — You can complain if you feel we have violated your rights by contacting the Privacy Officer for this Clinic, or the KU HIPAA Privacy Official at 785-864-9525. You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. **We will not retaliate against you for filing a complaint.**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will work to follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, and share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission — Marketing purposes, and sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. **Example:** Watkins and CAPS may exchange your information as necessary solely to provide you treatment in either unit.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. **Example:** We use health information about you to improve our services or for health education training.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. **Example:** We give information about you to your health insurance plan so it will pay for your services.

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OUR USES AND DISCLOSURES (continued)

How else can we use or share your health information?

Help with public health and safety issues — We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research — We will ONLY use or share your information for health research purposes when you have authorized it and when that research is approved under a strict new process and is compliant with federal regulations for human research.

Comply with the law — We will share information about you if local, state, or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests — We can use or share health information about you: 1.) For workers' compensation claims, 2.) For law enforcement purposes or with a law enforcement official, 3.) With health oversight agencies for activities authorized by law, 4.) For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions — We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

Each time you visit a University health clinic for services, a record is generated. This record contains medical information about you. This section explains a bit more of our responsibilities:

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it. You are always welcome to download the current electronic version from our website
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

_____ THIS NOTICE OF PRIVACY PRACTICES APPLIES TO THE FOLLOWING ORGANIZATIONS: _____



Counseling and Psychological Services
Watkins Memorial Health Center, Room 2100
The University of Kansas • Lawrence, KS 66045
785-864-2277

Watkins Health Services
Watkins Memorial Health Center, Room 2420C
The University of Kansas • Lawrence, KS 66045
785-864-9525

Schiefelbusch Speech-Language-Hearing Clinic
2101 Haworth Hall
The University of Kansas • Lawrence, KS 66045
785-864-4690

This notice also applies to our employees, volunteers, student trainees, student employees, and any health care professional authorized to enter information into your medical record.
Effective Date: 10/2014