

Anchorage School Based Health Centers

c/o Christian Health Associates, 2121 Abbott Rd., Anchorage AK 99507
907-742-0479 (office) or 907-917-6764 (cell)

Your student's school has additional health services available through **Anchorage School Based Health Centers (ASBHCs)**. These optional services are administered through a partnership with the Anchorage School District (ASD) and ASBHC to provide medical care AT school to keep students healthy and IN school. **PARENT CONSENT IS REQUIRED BEFORE ANY SERVICES ARE PROVIDED.**

Services available include comprehensive and age-appropriate care similar to what is provided in a pediatric or family medicine office, such as

- Acute illness and infection
- Injury assessment, treatment, and/or referral
- Physical exams*^
- Behavioral health services are available for a limited number of students when referred by a medical provider or school staff

**An annual physical exam – completed at school or from a healthcare provider in the community - is required for all students who participate in a school sport. More information can be found at*

<http://www.asdk12.org/activities/>

^If a physical is completed at school, insurance will not pay for another one at your regular doctor until the next calendar year.

Services are provided by licensed healthcare providers such as physicians, advanced nurse practitioners, and physician's assistants. All families are encouraged to have a medical home and ASBHC will coordinate with your child's private health care provider for any services received at school. Students are encouraged to provide information regarding any current treatments or medications that may affect the services received from ASBHC. Using the ASBHC is convenient for parents, who do not need to worry about taking time off work or arranging transportation to take their child to the doctor. Students are encouraged to discuss their health concerns with their parents. Urgent care visits may be communicated via a phone call to parents. The clinic will mail home a copy of the ASD physical form, as well as any health concerns that we are permitted to discuss under applicable privacy laws. Parents should be aware that under Alaska law, minors are permitted to confidentially obtain services related to pregnancy, sexually transmitted diseases and other reproductive health.

Clinics are located in or near the school nurse's office. These services are in addition to, and in conjunction with, the school nurse. For emergencies, *911 will always be called for serious conditions.*

Although ASBHC services have a fee, we serve families regardless of ability to pay. ASBHC will submit bills to insurance, including Denali KidCare for physical exams and treatment of minor illnesses/injuries and other health services provided. Fees can be eliminated based on income and family size, which are reviewed on a case by case basis. Documentation such as tax forms, pay stubs, household expenses may be requested.

More information available online at <http://www.aksbhc.org>

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PARENT CONSENT FOR CLINIC SERVICES IS REQUIRED

The following consents allow your student to receive medical services through Anchorage School Based Health Centers. Services are provided by licensed health care professionals (such as physicians and advanced nurse practitioners). Students are seen by either a volunteer or a paid health care provider, depending on the schedule. If the student is seen by a volunteer provider, both the student and their parent/guardian should understand that their legal rights with regard to damages or injuries may be limited under Alaska law.

A Parent/Guardian may revoke consent at any time by notifying ASBHC in writing.

This consent allows ASBHC to provide services on an *as needed* basis after referral by the school nurse. By providing consent, you understand that there are no guarantees about the results of the examinations, treatments or other services provided by ASBHC.

I give consent for my student to receive medical services at school through Anchorage School Based Health Centers. Services include:

- General healthcare similar to what is found at a pediatrician's office or family medicine office.
- Acute illness and infection such as (ear infections, strep throat, skin disorders, etc.)
- Injury assessment and treatment and/or referral
- Physical exams which include physical assessment, wellness promotion (eating habits, nutrition, exercise, and growth (height/weight), safety (seatbelts, bike helmets, etc.), limiting screen time, disease prevention, etc.

If you do not consent to medical care for your minor child through ASBHC, your student will not receive ASBHC services unless you register them with ASBHC in the future.

➤ PHYSICAL EXAM

I give consent for my student to have a comprehensive physical exam from Anchorage School Based Health Centers during the current school year. This exam meets the

requirements for a sports physical. This consent also includes permission for my student to be screened for high cholesterol and high blood sugar, if indicated, based on American Academy of Pediatrics guidelines. These tests are performed on site and involve a finger-stick blood sample, which will be destroyed following testing. *If a physical is completed at school, insurance will not pay for another one at your regular doctor until the next calendar year.*

OR

I do not want my child to receive a physical exam at this time but understand I can request a physical exam in the future.

Student Name:	Date of Birth:
Parent/Guardian Name:	Phone:
Parent/Guardian Signature:	Date:

More information available online at <http://www.aksbhc.org>

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Initial here

PRIVACY POLICY I acknowledge receiving a copy of Anchorage School Based Health Centers HIPAA Notice of Privacy Practices (scroll down to view).

Would you like ASBHC to send a copy of the visit notes to your primary provider? ____ Yes ____ No

Primary Medical Provider/"Medical Home" (if any):

INSURANCE/PAYMENT INFORMATION

We are dedicated to making healthcare affordable and accessible to all students. We accept all insurance plans and welcome Medicaid/Denali Kid Care. Fees will be waived for families, based on family size, who report an income 200% below the federal poverty guidelines. Additional documentation may be requested. We do not send accounts to collections, but failure to pay may result in the inability to receive further services. No money will be collected from students at the time of services. No one will be denied service based on inability to pay.

Initial here

I understand that if a physical is completed at school, insurance will not pay for another one at your regular doctor until the next calendar year. If a physical has been done this year, I understand that I am responsible for charges related to this visit.

INSURANCE TYPE – PLEASE NOTIFY US IF THIS INFORMATION CHANGES

Medicaid/Denali Kid Care

Private Insurance

TriCare

No insurance/Self Pay

Insurance ID Number:

Insurance Subscriber's Full Name:

Parent/Insurance Subscriber's Date of Birth:

Patient's relationship to subscriber:

Insurance Company Name:

Insurance Company Mailing Address:

Sliding Fee Scale Information

Below must be complete to waive fees if below 200% of the federal poverty guidelines. *Without it and/or insurance information, you will receive a full bill for the services provided. Please provide tax forms, pay stubs, household expenses and other documentation necessary to support the information provided below.*

Household Size:

Household Monthly Income: \$_____ OR

Household Annual Income: \$_____

I understand there is a fee for the ASBHC services. I acknowledge that the information provided is correct and it will be used to manage my account and process insurance claims. If the services are covered by insurance, I assign all reimbursement for such services to Anchorage School Based Health Centers and request that the insurance company pay the provider directly. If the visit is not covered by insurance, I understand that I am responsible for all fees incurred by my student at ASBHC. I consent to the disclosure of information necessary to obtain payment from my insurance company.

I have read the information provided above. If I have questions about this form, I understand that I can ask a staff member at 907-742-0479 before signing. By signing below, I confirm that the information provided is accurate and agree to the terms of treatment and payment.

Parent/Guardian Signature:

Date:

More information available online at <http://www.aksbhc.org>

Anchorage School District

Sports Physical - Health Examination Form

This form is valid for 18 months unless there is a change in health status due to illness or injury.

MEDICAL HISTORY TO BE COMPLETED BY LEGAL PARENT/GUARDIAN

Last Name (print) _____ First Name _____ Initial _____ Date of Birth _____

1. Have you ever been hospitalized? Y ___ N ___
2. Have you ever had surgery? Y ___ N ___
3. Are you presently taking any medications or pills? Y ___ N ___
4. Have you ever passed out during or after exercise? Y ___ N ___
5. Have you ever been dizzy during or after exercise? Y ___ N ___
6. Have you ever had chest pain during or after exercise? Y ___ N ___
7. Do you tire more quickly than your friends during exercise? Y ___ N ___
8. Have you ever had high blood pressure? Y ___ N ___
9. Have you ever been told that you have a heart murmur? Y ___ N ___
10. Have you ever had racing of your heart or skipped beats? Y ___ N ___
11. Has anyone in your family died of heart problems or sudden death before age 50? Y ___ N ___
12. Do you have any skin problems (itching, rashes, acne)? Y ___ N ___
13. Have you ever had a head injury? Y ___ N ___
14. Have you ever had a concussion? If yes, how many _____ Y ___ N ___
15. Have you ever been knocked out or unconscious? Y ___ N ___
16. Do you suffer from migraines? Y ___ N ___
17. Have you ever had a seizure? Y ___ N ___
18. Have you ever had a stinger, burner or pinched nerve? Y ___ N ___
19. Have you ever had heat or muscle cramps Y ___ N ___
20. Have you ever been dizzy or passed out in the heat? Y ___ N ___
21. Do you have trouble breathing or do you cough during or after activity? Y ___ N ___
22. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)? Y ___ N ___
23. Have you ever had problems with your eyes or vision? Y ___ N ___
24. Do you wear glasses or contacts or protective eye wear? Y ___ N ___
25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? Y ___ N ___
___ Head ___ Thigh ___ Elbow ___ Chest ___ Shin/calf ___ Wrist ___ Hip
___ Shoulder ___ Neck ___ Knee ___ Forearm ___ Back ___ Ankle ___ Hand
26. Have you ever had other medical problems (infectious mononucleosis, diabetes, etc.) Y ___ N ___
27. Have you had any medical problem or injury since your last evaluation? Y ___ N ___
28. Are you Diabetic? Y ___ N ___
29. Are you Asthmatic? Y ___ N ___
30. Do you have any allergies (medicine, bees or other stinging insects) _____ Y ___ N ___

List all allergies: _____

31. Explain all "yes" answers _____

Consent information:

- I hereby consent to emergency treatment, hospitalization or other medical treatment as may be necessary by a physician, qualified nurse, or hospital in the event of an injury or illness.
- I hereby consent to participation in ASAA approved interscholastic activities.
- I hereby consent to travel to and from ASAA activities via school approved transportation.
- I hereby waive on behalf of myself and the above student any liability of the school or ASAA organizationally or for any of its officers, agents or employees for injuries sustained in the interscholastic program.
- I accept financial responsibility for the above student in the event of an injury or illness.
- I hereby state that information submitted on this form is true.
- I hereby consent to abiding by the ASAA rules and regulations and school handbook.
- I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director, coaches and athletic trainers of any interscholastic activities in which I seek to participate.

Student Signature _____ Parent Signature _____ Date _____

HEALTH EXAMINATION TO BE COMPLETED BY HEALTHCARE PROVIDER - MD, DO, ANP, PA

Age _____ Height _____ Weight _____ Blood Pressure _____

Vision R/20 _____ Vision L/20 _____

Circle any of the following that are abnormal and explain under "comments":

- | | | |
|-----------------------|-------------------------------|-----------------------|
| Eyes/ears/nose/throat | Genitalia, Tanner stage _____ | Knee/hip |
| PERRLA | Neurological | Back |
| Respiratory | Skin | Ankles |
| Cardiovascular | Head/neck | Other musculoskeletal |
| Liver/spleen/abdomen | LAB: UA, HGB/HCT (as needed) | DT (date): _____ |

Comments: _____

I certify that on this date, I have examined this student and find him/her physically able to compete in all supervised activities not crossed out:

- | | | | |
|---------------|----------------|-----------------|------------|
| Baseball | Football | Softball | Wrestling |
| Basketball | Gymnastics | Swimming | XC running |
| Bowling | Hockey (boys) | Tennis | XC skiing |
| Cheer | Hockey (girls) | Track & Field | |
| Diving | Riflery | Volleyball | |
| Flag Football | Soccer | Weight Training | |

HCP Name (MD, DO, ANP, PA) (print) _____

Signature _____ Date of exam _____

Address _____ **Healthcare provider stamp is required here**

City _____ State _____

Phone _____ Zip _____

This form is valid for 18 months unless there is a change in health status due to illness or injury.

Anchorage School Based Health Centers

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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 an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct 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 information

- You can ask for a list (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 any you asked us to make). 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.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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 our Executive Director at 907-742-0479 or by mail at 2121 Abbott Road, Anchorage, AK 99507.
- 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, calling 1-877-696-6775, or 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 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
- Share information in a disaster relief situation
- Include your information in a hospital directory

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
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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, including the school nurse.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

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 manage your treatment and services.

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.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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 can use or share your information for health research.

Comply with the law

We will share information about you if 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.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- 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

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly 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.
- If we receive protected health information from an organization covered by 42 CFR Part 2 (Substance Use Confidentiality) through a general consent, we will maintain the privacy in accordance with HIPAA. If we receive it through a specific consent that continues to apply the protections of 42 CFR Part 2, we will not re-release it without your consent, unless permitted by law. Any request for substance use records covered by 42 CFR Part 2 will not be used or disclosed in any civil, criminal, administrative or legislative proceedings against you without your consent or a court order.

- 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.

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

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.

Other Instructions for Notice

- These policies are effective beginning January 1, 2026.
- If you have questions or comments, please contact ASBHC Executive Director at 907-742-0479.
- We never market or sell personal information.