



Attention Parents/Guardians:

Your student's school and Valley Professionals Community Health Center, Inc. (VPCHC) have partnered to operate a school-based health clinic in the school building. The goal is to help your family by providing these medical services for students while they are in school, assisting your child's physician with their healthcare needs, and providing access to high quality healthcare for those who do not have any healthcare services.

Our clinics are staffed with Nurse Practitioners (NP). An NP has a master's degree, or higher, and has been trained and licensed by the state to diagnose and treat. Our NP can be your child's primary care provider, but we do not intend to replace your child's current provider. We are here to support and complement your child's existing care.

In accordance with Indiana State Law, all families wishing for their students to receive health services from VPCHC School-Based Clinics (SBC) must have the student's Parent or Legal Guardian sign and submit an *Informed Consent* form and complete a brief medical history annually. This information provides our medical staff with the most up-to-date information for your child. Any information given will remain confidential as part of your child's medical record. The consent form will be invalid if any portion of the form is not fully complete.

Important:

- This consent is accepted at any school with a VPCHC School-Based Clinic.
- This consent is valid for one year.
- Parents/Guardians may provide a written request to withdraw consent and treatment at any time.
- Parents/Guardians are responsible to notify VPCHC clinic staff of any changes to the student's health history, or guardianship and/or demographic information.
- VPCHC will bill for services and collect from any third-party insurance your child may have. For this reason, we require your health insurance information be provided to provide services. Families who are unable to pay may qualify for VPCHC's Sliding Fee Schedule and will be assisted by a VPCHC Navigator to determine eligibility and available financial assistance options.
- This consent gives permission for an CMA, LPN, or RN to initiate a telemedicine appointment with a VPCHC Nurse Practitioner.

Thank you for your cooperation and allowing us the privilege to participate in your child's health care needs.

Notice of Privacy Practices Summary Notice

Effective Date: April 14, 2003

Revised Date: January 28, 2026

This summary describes how VPCHC uses and shares your child’s information and how you may acquire copies of this information. The full Notice of Privacy Practices is available at valleyprohealth.org, by scanning the QR code at the bottom of the page, and at each of our clinics. We may use or share your child’s information for the following:

- Treatment – such as discussions of your child’s care amongst the medical staff
- Payment – such as billing insurance for services provided to your child
- Operations – such as working to improve our quality of care, advertising services provided, etc.
- Other ways – such as mandatory disease reporting to county and state health officials, responding to court requests, appointment reminders, test result letters, etc.

Exceptions:

Different laws may apply to mental health, family planning, drug and alcohol and AIDS/HIV treatment. Any other reasons for use or sharing of your child’s health information will be completed only with your specific written permission or as required by law.

Regarding your child’s health information, you have the following rights:

- Requesting restrictions on how your child’s information is shared. VPCHC is not required to agree to requested restrictions but will notify you if we cannot accommodate your request.
- Acquire and inspect a copy of your child’s health record.
- Ask that incorrect or incomplete information in your child’s medical record be corrected.
- Ask that we contact you by mail or phone to an alternate address and/or phone number.
- Change your mind if you previously granted sharing/use of your child’s information for reasons other than those listed above.
- Receive a list of the times we shared your child’s information. This list will only contain the times that the law requires us to record.
- Some of your child’s health information may be protected by federal confidentiality laws for substance use disorder (SUD) treatment records, also known as 42 CFR Part 2 (“Part 2”). These laws provide additional privacy protections beyond those required by the Health Insurance Portability and Accountability Act (HIPAA).

Changes:

As we serve our patients, we may change how we handle your child’s information. You may call or write at any time to check if we have made any changes.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with VPCHC’s Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services. Your care will not be affected in any way if you choose to file a complaint.

Please address questions or complaints to:

VPCHC Privacy Officer
777 S. Main Street, Suite 100
Clinton, IN 47842
(765) 828-1003

The QR codes link to the full versions of the
Notice of Privacy Practices and the Patient Bill of Rights:



Notice of Privacy Practices



Patient Bill of Rights

**Informed Consent for School-Based Health Clinic Services
as provided by Valley Professionals Community Health Center, Inc.**

I give permission for (Student/Patient's Full Name) _____ (Date of Birth) _____ to receive health services from the VPCHC school-based clinic (SBC) at my child's school. I understand that the SBC provider does not replace my child's Primary Care Provider and may not be able to take care of all my child's health care needs.

- I. I have read the information provided regarding the SBC and the release of information and I understand what services the clinic will and will not provide. My consent will allow my child to receive health services while they are a student at any school with a VPCHC SBC during the effective period. I understand that if I choose to cancel these services, I must provide the request in writing. It will be my responsibility to notify the clinic staff regarding changes in guardianship, contact information, and health history.
- II. Information Privacy: I have been informed that VPCHC has prepared a detailed NOTICE OF PRIVACY PRACTICES regarding my child's personal health information. I understand that the terms of the notice may change, and current notices will be available on VPCHC's website and facilities.
- III. Release of Information: I understand the services provided by the SBC clinic are confidential. The clinic will use and disclose my child's personal health information to provide treatment and/or improvement of health care operations. My child's information may be shared with my child's physician/provider, appropriate school staff, or with my child's insurance provider for legitimate purposes. I authorize the release of my child's medical information to other providers who may have my child as a patient. I also authorize the use of information from my child's medical record for the purposes of medical care, treatment, clinic administration and evaluation. In addition, I give my consent to the clinic staff to look at, and update my child's school health record, including immunizations.

_____ (Parent/Guardian *Initials*) I acknowledge I have received access to Valley Professionals Community Health Center, Inc. Notice of Privacy Practices and Bill of Rights.

Note: An electronic signature, like an in-person signature, is valid and sufficient to give consent.

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Parent/Guardian: _____ Relationship: _____

INSURANCE INFORMATION (REQUIRED SECTION)		
Insurance coverage is NOT required to be seen in a VPCH clinic; however, this section MUST be completed.		
<input type="checkbox"/> Medicaid Type: _____	Member ID: _____	
<input type="checkbox"/> Private Insurance: _____	Member ID: _____	
Group Number: _____	Name of Policy Holder: _____	Policy Holder's DOB: _____
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Please refer my family to a free insurance navigator to help with all options available.	
*As a Federally Qualified Health Center, VPCHC is required to attempt to collect yearly household size and income information in order to continue receiving special funding for our school-based clinics. Please support our programs by providing the following information:		
Number of people living in home: _____	Total household income: _____	<input type="checkbox"/> Choose not to disclose
		<input type="checkbox"/> Unhoused

SERVICES WILL NOT BE PROVIDED WITHOUT A SIGNED PARENTAL/GUARDIAN CONSENT AS REQUIRED BY THE INDIANA STATE LAW.

STUDENT/PATIENT INFORMATION

Patient Legal Last Name: _____ **Patient Legal First Name:** _____
Preferred Name: _____ **Date of Birth: (mm/dd/yyyy)** _____
Mailing Address: _____ **City:** _____ **Zip Code:** _____
Parent/Guardian email: _____ **Parent/Guardian Phone #: ()** _____

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ <input type="checkbox"/> Interpreter needed	Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White	<input type="checkbox"/> Native American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Choose not to disclose
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Pharmacy of choice & location: _____ **School:** _____

DAYTIME & EMERGENCY CONTACTS

	Name	Relationship to student	Phone
1.			()
2.			()
3.			()

EMERGENCY CONTACT if Parent/Guardian cannot be reached:

4. _____	_____	()
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HEALTH INFORMATION- Please mark Yes or No for ALL questions

Does your child have or has had...	NO	YES	If yes, please give all details in the section below
Allergies			What kind? What was their reaction? What treatment was required?
Medicine			
Food			
Other			
Any medications they take daily or sometimes?			Medication name:
			1. _____
			2. _____
			3. _____
Surgery in the past			What surgery? When was the surgery?
Diabetes			
Environmental or Seasonal Allergies			
Headaches / History of Head Injury			
Hearing Problems			
Heart Disease / Murmurs / High Blood Pressure			
Kidney or Bladder Problems			
Learning Difficulties			
Lung Problems, Including Asthma			
Mental Health Concerns (Depression, ADHD, Autism, etc.)			
Seizures			
Sickle Cell Disease			
Skin Problems (Eczema, etc.)			
Stomach Problems, Including Constipation			
Vision Problems, Including Glasses			
Other:			

VPCHC Staff Signature: _____ **Date:** _____