Youth Program / Camp Participant
Health Services Information
And
Required Forms
TO DIRECTORS OF YOUTH PROGRAMS / CAMPS – For 2016

Dear Program Director:

Watkins Health Services (WHS), on the KU campus wants to be your program’s health care provider. WHS provides youth program participants with the same high quality health care that KU students receive, and from the same certified professionals. These services include: Medical evaluations, allergy injections, pharmacy, laboratory and X-rays. All of our 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 do prefer appointments to be scheduled, we certainly understand that issues arise which require prompt attention. Therefore, we do have a Walk-In / Triage process to provide an immediate evaluation of the individual’s needs. While we are not an Emergency Room, we do stabilize and transfer patients when that is needed.

Enclosed you will find the following forms that should be completed by each participant’s parent or guardian.

- Health Form
- Treatment Agreement

Please have the family return the packet to you so that when a youth program participant is brought to WHS for care, it should accompany the youth to ensure we have the best possible information on his/her health history as well as emergency contact information. If the participant is never brought to WHS for care during your program, please return the packet of information to the parents. It is very important that your office NOT retain this medical information once your program has ended.

We function very much like a medical clinic where patients are seen by nurses, nurse practitioners and physicians. WHS is not an Emergency Room but we will stabilize and transfer all urgent and emergent conditions. 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 we are not a participating provider with these or similar government programs.

Youth program / camp participants often bring personal medications to campus, which are sometimes forgotten and left behind when they return home. Many of these medications are quite expensive, so please be sure they are sent home with the participants, or mailed to them if medications are found after the participants leave. Our Pharmacy (by state law) cannot accept for disposal or for mailing any prescription medications or over-the-counter medications.

For our Hours of Operation and other information, please visit our website: [http://www.studenthealth.ku.edu/](http://www.studenthealth.ku.edu/)

If we can be of further assistance or answer any questions, please feel free to contact our Business Office at 785-864-9520.

Douglas Dechairo, M.D.
Director and Chief of Staff
Watkins Health Services
## Youth Program Participant’s Health Form

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

### Name of Program / Camp:

____________________________________________________________________________

### Name & Contact Information for Program’s Director:

_____________________________________________

____________________________________________________________________________

#### Youth’s Name

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

#### Birth Date

Sex

#### 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?**

   - [ ] YES
   - [ ] NO

   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
   - [ ] kidney problems
   - [ ] tuberculosis
   - [ ] cardiac
   - [ ] headaches
   - [ ] other  _______________________________________________

3. **Has the youth had any other significant illnesses, injuries, or surgeries?**

   - [ ] YES
   - [ ] NO

   If yes, please explain __________________

4. **Medications and their dosages taken by the youth**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason Taken</th>
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<tbody>
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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)
   - DPT 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?**

   - [ ] YES
   - [ ] NO

   If yes, please list _______________________________________

7. **Does the youth have any other allergies?**

   - [ ] YES
   - [ ] NO

   If yes, please list _______________________________________

8. **Do any allergies require an EPI Pen injection?**

   - [ ] YES
   - [ ] NO

   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. And if I have no insurance coverage, 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 ____________________
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 (WHS) 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. We have included a copy with this packet.

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.

_______________________________  Date: ______________________
Print Name of Youth Program Participant

_______________________________
Signature (Parent, Guardian or Representative)  Relationship to Participant

_______________________________
Print Name of Parent, Guardian or Representative

WATKINS HEALTH SERVICES
THE UNIVERSITY OF KANSAS

AD-309-2
R-2/12/2016
**Notice of Privacy Practices**

**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.

- **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 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. **Example:** 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.

- **How else can we use or share your health information?**
We may contact you regarding your appointments or prescriptions or to tell you about other health-related services we offer or benefits to which you are entitled. 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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

(continued on page 2)
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
785-864-9523

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