



Watertown City School Districts SBHC Locations

Case Middle School: 315.785.3809

North Elementary: 315.786.1767

Harold T. Wiley: 315.785.3783

Harold T. Wiley Dental: 315.779.5611 (*Covers all dental sites*)

Watertown High School: 315.785.3703

Dear Parent/Guardian:

North Country Family Health Center's School-Based Health Program, within the Watertown City School District, offers medical, dental, and behavioral health services to all students through our School-Based Health Centers (SBHCs). SBHCs bring comprehensive primary care services to the place where students are during the day – school – and address critical health problems as well as urgent concerns that make it difficult for students to learn.

Our SBHCs offer a full range of primary healthcare services to ANY student within the Watertown City School District. Services include the following:

- *Well child and annual physical exams – (including sports physicals and working papers)
- *Immunizations
- *Care for sick visits
- *Care for chronic issues
- *Counseling services – individual and family counseling
- *Preventative dental care – (including cleanings, sealants, and fluoride treatments)

Services provided within the SBHC are provided at no out of pocket costs to you – regardless of your child's health insurance coverage. However, if your child requires services we do not provide at our school-based sites – such as outside tests or labs – there may be out of pocket costs. If your child has insurance, we will bill your insurance company for you. If your child does not have insurance, we can assist you with obtaining insurance coverage. We do NOT turn any student away!

The best part – you do not need to change your primary care provider (medical or dental). Our staff will work in collaboration with any outside provider your student is already seeing.

Our Program is voluntary – however, we encourage you to enroll as a backup plan in case your child falls ill while at school as well as to take advantage of our school-based services as they are convenient for both you and your child. North Country Family Health Center has 30 years of experience providing school-based services to students within the Watertown School District and we know firsthand that healthy students learn better. We encourage you to enroll your child so we can focus on their health so they can focus on learning.

Please complete the attached enrollment packet to enroll your child in school-based services. If you would like more information or have questions, please don't hesitate to reach out to me directly at any time at either hlupia@nocofamilyhealth.org or 315-782-9450 x8086.

Sincerely,

Heather Lupia, MS, Healthcare Administration
SBHC Program Administrator



Use our QR code to learn more about our SBHC program.



Completion of Enrollment Form
is **Required** Each Year

Today's Date:

**School-Based Health Center (SBHC)
2023-2024 School Based Enrollment Form**

Medical/Dental School-Based Health Center Enrollment:

What Services do You Want to Enroll Your Student in: ☐ Medical ☐ Dental ☐ Counseling Services

Student Information:

Last Name:	First Name:	Full Middle Name:
Date of Birth:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Biological Mother's Maiden Name:
Street Address:		
Student's School:	Grade:	Teacher/Homeroom:

Parent/Guardian Information:

Name:	Name:
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:	Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:
Mailing address if other than student's address:	Mailing address if other than student's address:
Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message/text: <input type="checkbox"/> Yes <input type="checkbox"/> No	Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message/text: <input type="checkbox"/> Yes <input type="checkbox"/> No
Who Does the Student Live With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Other:	
Who Will make Healthcare Decisions for This Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Other:	
Do we have permission to call the student's emergency contact you provided to the school: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Pharmacy:	Address:

**North Country Family Health Center, as a Federally Qualified Health Center, MUST Ask You to Complete the Following Questions
(PLEASE FILL OUT ALL SECTIONS BELOW):**

Household Size & Income (For Children Enter Family Information):
Number of People in the Household: _____ Income \$ _____ ☐ Week ☐ Month ☐ Year

What Gender Do You Identify as:
☐ Male ☐ Female ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female
☐ Gender Non-Conforming (neither exclusively male nor female)
☐ Additional Gender Category /other please specify: _____ ☐ Choose Not to Disclose

Sexual Preference/What Do You Think of Yourself as:
☐ Straight/heterosexual ☐ Gay/Lesbian/homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Pronouns Preferred: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Choose Not to Disclose

Primary Medical Insurance

☐ The Student **Has** Medical Insurance
☐ The Student **Does Not** have **Medical** Insurance
Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.

Insurance Company Name:

Medical Policy #:

Billing Address of Insurance Co:

Dental Insurance

☐ The Student **Has Dental** Insurance
☐ The Student **Does Not** have **Dental** Insurance
Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.

Insurance Company Name:

Dental Policy #:

Billing Address of Insurance Co:

Student Name: _____

Date of Birth: _____

Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
<input type="checkbox"/> I have additional Medical Insurance (name of insurance co.):	<input type="checkbox"/> I have additional Dental Insurance (name of insurance co.):

School-Based Health Center Enrollment:

Student's Doctor's Name:	<input type="checkbox"/> My Student Doesn't Have a Regular Doctor
Student's Dentist Name:	<input type="checkbox"/> My students Doesn't have a Regular Dentist

North Country Family Health Center Policies and Consents**Consent for School-Based Health Services 2023-2024**

I authorize my student to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Health/Dental and Counseling Programs at a NCFHC School-Based Health Center. Services may include but are not limited to: comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and counseling services, if needed. I consent to photographs being taken of the student for inclusion in their confidential electronic medical record for diagnosis and treatment only. I give my consent for NCFHC staff to have access to the student's school health records and copies of the student's most recent physical/dental exam. I give my permission for the release of the student's medical/dental summaries to be shared with his/her healthcare provider and/or the school nurse to coordinate his or her care. I understand that every effort will be made to contact me prior to treatment, however I understand this may not always be possible. The staff of NCFHC believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in healthcare decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time.

North Country Family Health Center Policies and Consents**Permission to Disclose to Family or Other Individuals****Pediatric Consent**

Non-Parental Consent: For pediatric patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions.

☐ **No**, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

☐ **Yes**, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for services and to make treatment decisions for my child in my absence. This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s):	Relationship to Student:

Finance Policy:

North Country Family Health Center's (NCFHC) School-Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have NO out-of-pocket costs. However, if the student requires services, we do not provide at the SBHC – outside tests or labs – there may be out of pocket costs incurred. If you have insurance, we will bill your insurance company for you. If you do not have insurance, we can assist you with obtaining insurance coverage.

I authorize NCFHC and its representatives to release any information they obtain, including medical information to your insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay North Country Family Health Center, Inc. for services rendered.

Notice of Privacy Practices:

A copy of North Country Family Health Center's (NCFHC) Notice of Privacy Practices which describes how NCFHC may use and disclose my student's protected health information following applicable state and federal law is posted in the SBHC. Please visit www.nocofamilyhealth.org for a copy.

I understand that this may include disclosures of information to my student's insurance carrier(s) to issue payment directly to NCFHC.

I understand that I have the right to receive a copy of my student's medical/dental/behavioral health information or to request restrictions on the use of my student's protected health information.

I understand that NCFHC may engage business associates to assist in my student's coordination of care including afterhours telephone coverage, Parkview Pharmacy, and call reminder service including text messages.

I understand NCFHC may use letters, reminder calls, text messages, or secure email correspondences to communicate with me regarding my student's care. I authorize NCFHC to communicate with me via these methods and understand this correspondence may contain PHI.

Student Name: _____

Date of Birth: _____

Telehealth: North Country Family Health Center's (NCFHC) offers its patients telehealth services as a method to expand access to care. I understand my student may be offered a telehealth appointment at NCFHC. I consent for my student to receive services via NCFHC telehealth equipment and understand and/or agree to the following:

- I understand my student has the right to refuse to participate in services delivered via telehealth at any time by informing any NCFHC staff member.
- I may request at any time an in-person appointment with another NCFHC healthcare provider. I understand that by selecting another provider there could be a delay in service and the potential need to travel for a face-to-face visit.
- I understand there are potential drawbacks of participating in a telehealth visit versus a face-to-face visit.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my student's care and treatment require physical examination that may be conducted by other NCFHC providers and staff under the direction of my student's telehealth healthcare provider or my student may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand my student's visit will be conducted via technology and NCFHC cannot guarantee technology will always work. I understand that if there is an equipment failure my student may need to be rescheduled for a face-to-face visit.
- I understand NCFHC utilizes HIPAA compliant, encrypted software to conduct its telehealth services.
- I understand my student has the right to ask any questions regarding the telehealth equipment, technology, etc. at any time.
- I understand my student will be informed and made aware of: the role of the telehealth provider at the distant site, as well as qualified professional staff at the NCFHC location who are going to be responsible for follow-up or ongoing care; and the location of the distant site.
- I understand my student has the right to have appropriately trained staff immediately available while receiving the telehealth service to attend to emergencies or other needs. I understand this is not possible if conducting a telehealth visit from my place of residence located within the state of New York or other temporary location within or outside the state of New York.

I understand my student has the right to be informed of all parties who will be present at each end of the telehealth transmission; and consent to have NCFHC staff in the exam room to operate telehealth equipment, if needed.

My Signature Means:

I have reviewed and completed the Consent for School-Based Health Medical, Dental, and Counseling Services and Permission to Disclose to Family or Other Individuals sections. I understand that when I designate another person to authorize a treatment decision, North Country Family Health Center may disclose protected health information to the authorized person(s).

If I have questions about enrolling my student and the SBHC Program, I will contact SBHC Program Administrator Heather Lupia at (315) 782-9450 x 8086.

I understand that my consent will remain in effect as long as the student is enrolled in NCFHC's SBHC Program, unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.

Printed Name of Legally Authorized Representative:

Relationship to Student:

Signature of Legally Authorized Representative:

Date:

Please Complete the Medical/Dental History on Next Page:

Student Name: _____

Date of Birth: _____

Please Complete Medical/Dental History Below:

Medical/Dental History Form:	
Has your student been diagnosed with any of the following? <input type="checkbox"/> ADHD/Mental Health Issues <input type="checkbox"/> Asthma <input type="checkbox"/> Autism <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac Issues <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Growth Problems <input type="checkbox"/> Kidney/Urinary Issues <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid Issues <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other:	
Last Physical Exam was on (provide date):	Provider name:
Has your student had any surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list):	
Has your student been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list):	
Has your student been referred to a Healthcare Specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes (name & phone #):	
Daily Medications: <input type="checkbox"/> No <input type="checkbox"/> Yes (please list):	
Does the student have any current dental problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list):	
Has the student had problems with dental treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain):	
Has the student had any injury to the mouth or teeth? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain):	
Does anyone in the home smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	

CONSENT FOR RELEASE OF MEDICAL INFORMATION

****Complete this Form if the Student is NOT a Current Medical Patient of North Country Family Health Center to Ensure Coordination of Care with your Child's Primary Care Provider****

Student's Name:	Student's Date of Birth:	Student's SS#:
Student's Address:		
<p>I, the student's authorized representative, request that health information regarding my student's care and treatment be released as set forth on this form. I understand that with some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I have the right to revoke this authorization at any time by writing to the student's primary care provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my student's treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.</p>		
Student's Primary Care Provider's Name:		
Name and Address of Provider of Whom this Information will be Disclosed: North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601		
Purpose of Release of Information: Collaboration and continuity of care between student's primary care provider and student's School-Based Health Center.		
Type of Information to be Released (check all that apply): <input type="checkbox"/> Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues. <input type="checkbox"/> Clinical records of mental health treatment <input type="checkbox"/> HIV/AIDS-related information <input type="checkbox"/> Records from alcohol/drug treatment programs		
Unless previously revoked by me in writing, this release is effective from <u>the date below to one year after signing</u> .		
Name of Authorized Person Signing the Form:	Relationship to the Student:	
Signature of Authorized Person:	Date:	

CONSENT FOR RELEASE OF DENTAL INFORMATION

****Complete this Section if the Student is NOT a Current Dental Patient of North Country Family Health Center to Ensure Coordination of Care with your Child's Dentist****

Student's Dentist's Name:	
Name and Address of Provider of Whom this Information will be Disclosed: North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601	
Purpose of Release of Information: Collaboration and continuity of care between student's dentist and student's School-Based Dental Program.	
Type of Information to be Released: Clinical records related to the most recent dental exam, current diagnosis, and treatment of dental issues.	
Unless previously revoked by me in writing, this release is effective from <u>the date below to one year after signing</u> .	
Name of Authorized Person Signing the Form:	Relationship to the Student:
Signature of Authorized Person:	Date:



**Authorization for Access to Patient Information
Through a Health Information Exchange Organization**

New York State Department of Health

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called **HealthConnections**. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. **HealthConnections** is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit **HealthConnections** website at <http://healthconnections.org/>.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

<p>My Consent Choice. ONE box is checked to the left of my choice.</p> <p>I can fill out this form now or in the future.</p> <p>I can also change my decision at any time by completing a new form.</p>
<p><input type="checkbox"/> 1. I GIVE CONSENT for the Organization named above to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> 2. I DENY CONSENT for the Organization named above to access my electronic health information through HealthConnections for any purpose, even in a medical emergency.</p>

If I want to deny consent for all Provider Organizations and Health Plans participating in **HealthConnections** to access my electronic health information through **HealthConnections**, I may do so by visiting **HealthConnections** website at <http://healthconnections.org/> or calling **HealthConnections** at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Health_eConnections and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
 - **Treatment Services.** Provide you with medical treatment and related services.
 - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
 - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
 - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through Health_eConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.
3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Health_eConnections. You can obtain an updated list at any time by checking Health_eConnections website at <http://healthconnections.org/> or by calling 315.671.2241 x5.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Health_eConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the Health_eConnections website at <http://healthconnections.org/>; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Health_eConnections ceases operation (or until 50 years after your death, whichever occurs first). If Health_eConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Health_eConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.
10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

*****ONLY COMPLETE THIS FORM IF YOU WANT YOUR STUDENT TO RECEIVE COUNSELING SERVICES
BY A LICENSED SOCIAL WORKER IN THE 2023-2024 SCHOOL YEAR*****

REQUEST FOR SCHOOL-BASED COUNSELING SERVICES

Date of Request: _____	Name of School: _____	Grade: _____
PART I. FAMILY INFORMATION		
Child/Adolescent being referred (full name): _____ DOB: _____		
Parent/Guardian(s) requesting counseling services: _____		
Relationship to child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____ Sex at Birth: M F		
Address: _____ Phone: _____		
Home: _____ Cell: _____ Work: _____ OK to call work? Y N		
Who else may we talk to in the home when we call? _____		
Other residents of the home besides person requesting service and child being referred (please print):		
FULL NAME: _____ *AGE/GENDER _____	FULL NAME: _____ *AGE/GENDER _____	
_____	_____	
_____	_____	
_____	_____	
_____(A=Adult)	_____(A=Adult)	
PART II. REASON FOR REQUEST		
Does your child currently see a licensed Mental Health Therapist outside of school?		
Are you concerned about your child's attitude or behaviors? (please explain)		
Does your currently work with the school counselor?		
Do you have concerns with your child at school? <input type="checkbox"/> Poor Academics <input type="checkbox"/> Suspensions/Detentions <input type="checkbox"/> Attention concerns Comments: _____ Does your child get IEP counseling provided by the school?		
PART III. OTHER INFORMATION		
Insurance: _____		
<input type="checkbox"/> Medicaid		
<input type="checkbox"/> CHP		
<input type="checkbox"/> Other _____		
Date of Last Physical Exam: _____		
Name of Student's Primary Care _____		
Provider: _____		
PART IV. SIGNATURES		
I have received the letter describing the mental health referral process and a copy of the community resource list. <u>I understand that a parent/guardian's failure to attend and participate in the mental health evaluation/counseling services can affect the provider's ability to treat my student and can result in a referral to services elsewhere. I understand that the school-based social worker will collaborate with the school counseling staff and give permission for information to be shared.</u>		
<div style="display: flex; justify-content: space-between;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between;"> <div>Parent/Guardian Signature</div> <div>Date</div> </div>		

School-Based Health Center Transportation Plan & Consent

The Watertown City School District (WCSD) will provide transportation for students to and from appointments with North Country Family Health Center when school is in session. Transportation will be provided from 8:30 am to 11:00 am. **A parent permission form must be on file in order for WCSD to provide transportation.**

When students in grades K-4 have an appointment (scheduled), the transportation provider will go into the school to pick the child up and bring the student to the bus. He/She will transport the student to the appointment, walking him/her into the clinic. Either he will escort the student back to the bus or someone from the clinic will do so. Once the bus has returned the student to the school where he/she attends, the transportation provider will escort the student to the Main Office of that school building.

When a student in grades 5-12 must travel to an appointment outside of their building but still on the main campus, students will sign out of the building and walk to the building on campus (Wiley, Case, or WHS) where they have their appointment. Upon returning to their building of attendance, they will sign back in. Parent permission must be on file for students to walk from one building to another on the main campus. In the event that students in grades 5-12 have an appointment (scheduled) and must travel off the main campus for the appointment, the transportation provider will wait in front of the school to pick up the student. He/she will transport the student to the appointment, walking him/her into the clinic. Either he will escort the student back to the bus or someone from the clinic will do so. The bus will drop off the student at the main entrance of the school in which he or she is in attendance. It will be the student's responsibility to check in at the Main Office of Wiley Intermediate School, Case Middle School or Watertown High School.

The Watertown City School District and the North Country Family Health Center collaborate to offer K-12 students health and dental care. the district is able to provide transportation, mornings only, on an as needed basis, to and from any appointments; they may have with the health center clinics. If you wish to approve your child receiving transportation to and from these appointments (when scheduled during days school is in session), **YOU MUST complete the Information below.**

For the 2023-2024 school year, I authorize the Watertown City School District to provide my child with transportation to and from any appointments; they may have with the North Country Family Health Center. I understand that transportation is only provided on days when school is in session and during morning hours as applicable. If my child is a Watertown High School or Case Middle School student, I authorize him/her to walk from the respective building to Wiley Intermediate School for any appointments and back, signing in and out of the building as required by administration. If my child is a Knickerbocker, Starbuck, Sherman, or Ohio Street student who needs services, they will be provided transportation to North Elementary school for services.

Student's Name:

Grade:

Teacher:

Parent's Name:

Parent Signature:

Date:

