Board Office Use: **Legislative File Info.**	
File ID Number	15-1710
Introduction Date	9-24-15
Enactment Number	15-1486
Enactment Date	9/24/15 CB2

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Memo

To Board of Education

From Antwan Wilson, Superintendent

Board Meeting Date *(To be completed by Procurement)* 9/24/15

Subject Contract Agreement - Prescott-Joseph Center for Community Enhancement, Inc. (contractor) - 968/Health Services Department (site/department)

Action Requested

Approval of a Contract Agreement between Oakland Unified School District and Prescott-Joseph Center for Community Enhancement, Inc. Services to be primarily provided to Health Services Department for the period of September 1, 2015 through June 30, 2016.

Background
A one paragraph explanation of why the consultant's services are needed.

The Prescott-Joseph Center for Community Enhancement, Inc. (PJCCE) operates a school-based mobile asthma treatment program referred to as the "Mobile Clinic". They will work in conjunction with the Health Services Department to perform history and physical examinations, peak flow measurements, limited skin testing, spirometry, pharmacological therapy, annual flu vaccines, patient/parent education regarding environmental control measures, asthma management and treatment plans. They will also provide referrals for any additional treatment plans and medication forms.

Discussion
One paragraph summary of the scope of work.

Approval by the Board of Education of a Contract Agreement between the District and Prescott-Joseph Center for Community Enhancement, Inc., Oakland, CA, for the latter to provide a school-based mobile asthma treatment program for students with asthma for up to twenty sites to be selected in conjunction with the Health Services Department, for the period of September 1, 2015 through June 30, 2016, at no cost to the District.

Recommendation

Approval of a Contract Agreement between Oakland Unified School District and Prescott-Joseph Center for Community Enhancement, Inc. Services to be primarily provided to 968/Health Services Department for the period of September 1, 2015 through June 30, 2016.

Fiscal Impact

Funding resource name (please spell out): No Fiscal Impact

Attachments

- Contract Agreement
- Business Associate Agreement
- Certificate of Insurance
- Patient's Authorization for Release of Medical Information
- Permission Form for Parents/Guardians

Oakland Unified School District Breathmobile Contract

THIS CONTRACT is entered into in the State of California by and between Prescott-Joseph Center for Community Enhancement, Inc, hereinafter called PJCCE, and

Name
Oakland Unified School District — Hereinafter called District

Address
Health Services Unit

746 Grand Ave, Oakland, CA 94610

Telephone
510-273-1510

Federal ID No. or Social Security No.

IT IS HEREBY AGREED AS FOLLOWS:

(Use space below and additional bond sheets. Set forth service to be rendered, amount to be paid, manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)

This agreement ("Agreement") is entered into by and among Prescott-Joseph Center for Community Enhancement, Inc, hereinafter referred to as "PJCCE", and Oakland Unified School District, hereinafter referred to as "District".

WITNESSETH

WHEREAS, PJCCE, operates a school-based mobile asthma treatment program, hereinafter referred to as "Mobile Clinic";

WHEREAS, the District desires that PJCCE operate the Mobile Clinic on District property as set forth herein below;

NOW, THEREFORE, the parties hereto enter into this Agreement as a full statement of their respective responsibilities during the term of this Agreement, and in consideration of the representations made above and the covenants and conditions set forth herein, the parties agree as follows:

I. General Information:

1. The delivery of services by PJCCE will be on the premises of up to twenty-two (22) selected school sites, on days and at times as mutually agreed upon by both parties.

II. Obligations of PJCCE:

1. Be solely responsible for staffing and providing services under this Agreement. PJCCE certifies that staff and/or trainees providing the services are adequately trained and prepared according to prevailing professional standards for providing such services.

2. Provide adequate supervision of the professional staff and/or trainees.

3. Certify that PJCCE staff will follow legal guidelines on reporting child abuse.

4. Certify that all personnel in contact with children shall provide evidence of freedom from tuberculosis upon request of the District and that personnel meet District criminal conviction standards.

5. Be responsible for the cost, care and maintenance of the Mobile Clinic.

6. Be responsible for the services described herein with parent/guardian written approval. Services shall include:

   a. History and physical examination

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b. Limited skin testing

c. Spirometry

d. Pharmacologic therapy

e. Annual flu vaccines and other vaccines as indicated

f. Patient/parent education regarding environmental control measures, asthma management and treatment plans.

g. Referrals for additional care where indicated. If the services required cannot be performed at the designated location or by staff present, PJCCE will make its best efforts for referrals as may be appropriate to the patient's needs.

h. Provide asthma treatment plans, asthma action plans and medication forms to OUSD Asthma Nurse and student's primary care provider

7. Should services by PJCCE include any form of medical services, including diagnostic services, treatment or counseling, PJCCE shall obtain written parent consent prior to providing service(s) to a minor. Parents or Guardian will be present for all medical appointments.

III. Obligations of the District:

1. Provide the Mobile Clinic medical team with any necessary utilities, including electrical hookups, as required for the Mobile Clinic.

2. Health Services Unit shall:

a. Facilitate the education of OUSD faculty, staff and parents about the asthma mobile clinic and how to make referrals to the mobile asthma clinic

b. Collaborate with the asthma mobile clinic.

c. Assist in developing a plan to identify students with asthma who would benefit from the asthma mobile clinic services

d. Assist in the scheduling of clinic dates with school site principals and assist in scheduling students and parents for clinic visits.

e. Assist the school sites to understand the asthma status of students seen in the asthma mobile clinic utilizing individual treatment plans or asthma action plans.

f. Communicate with the asthma mobile clinic team regarding the asthma status of students seen in the asthma mobile clinic as allowed by HIPPA and FIRPA.

IV. Billing:

Services will be provided at no cost to the District or to the students served. PJCCE shall bill Medi-Cal and other third-party payers for eligible services.

V. Insurance:

PJCCE and District are self-insured entities for purposes of Professional Liability, General Liability, Automobile Liability and Workers' Compensation and warrant that through their respective programs of self-insurance, they have adequate coverage or resources to protect against liabilities arising out of the performance of the terms, conditions or obligations of this agreement.

VI. Indemnification:

PJCCE agrees to indemnify, defend (with counsel approved by DISTRICT) and hold harmless the DISTRICT its School Board, State Trustee, officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability resulting from the PJCCE'S negligent acts or omissions which arise from the PJCCE'S performance of its obligations under this Agreement.

DISTRICT agrees to indemnify, defend (with counsel approved by PJCCE) and hold harmless PJCCE and its officers, employees, agents and volunteers from any and all claims, actions, losses, damages and/or liability which arise from DISTRICT's negligent acts or omissions arising out if its obligations under this Agreement.

In the event PJCCE and/or the DISTRICT is found to be comparatively at fault for any claim, action, loss or damage which results from their respective obligations under the Agreement, the PJCCE and/or DISTRICT shall indemnify the other to the extent of its comparative fault.

VII. Status of Parties:

1. The parties hereby expressly understand and agree that this Agreement is not intended and shall not be construed to create a relationship of agent, servant, employee, partnership, joint venture, or association between District and PJCCE but is rather an Agreement by and between independent contractors.

2. The parties hereby expressly understand and agree that their employees, agents, and independent contractors are not the employees or agents of the other party for any purpose, including, but not limited to, compensation for services, employee welfare and pension benefits, other fringe benefits of employment, or workers' compensation insurance.

VIII. Assignment:

Neither party hereto shall assign its rights or obligations pursuant to this Agreement without the express written consent of the other party.

IX. Modification:

No modification, amendment, supplement to or waiver of any provision of this Agreement shall be binding upon the parties unless made in writing and duly signed by all parties.

X. Rules of Construction:

The language in all parts of this Agreement shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against either the PJCCE or the District. Section headings in this Agreement are for convenience only and are not to be construed as a part of this Agreement or in any way limiting or amplifying the provisions hereof. All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identifications of the person or persons, firm or firms, corporation or corporations may require.

XI. Governing Law:

This Agreement is made and entered into in the State of California, and shall in all respects be interpreted, enforced and governed by and under the laws of the State of California.

XII. Counterparts:

This Agreement may be executed in counterparts, and all such counterparts together shall constitute the entire Agreement of the parties hereto.

XIII. Severability:

The provisions of this Agreement are specifically made severable. If any clause, provision, right and/or remedy provided herein is unenforceable or inoperative, the remainder of this Agreement shall be enforced as if such clause, provision, right and/or remedy were not contained herein.

XIV. Alternative Dispute Resolution:

In the event the District determines that service is unsatisfactory, or in the event of any other dispute, claim, question or disagreement arising from or relating to this Agreement or breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect, they shall consult and negotiate with each other in good faith and, recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties.

Notwithstanding the above, nothing herein shall preclude either party from pursing its legal remedies at law in the event a mutually satisfactory solution is not reached.

XV. Term and Termination:

1. This agreement shall be effective commencing on the execution of this agreement by both parties and terminating June 30, 2016 at which time the agreement shall automatically renew for successive one year terms thereafter. However, this agreement may be terminated, with or without cause, by either party after giving the other party sixty (60) days advance written notice of its intention to terminate. The Director of the Medical Center is authorized to initiate termination on behalf of PJCCE.

2. Any written notice given under this Section XV shall be sent, postage prepaid, by certified mail, return receipt requested, to the following person(s), as the case may be:

Prescott-Joseph Center for Community Enhancement, INC
920 Peralta Street
Oakland, CA 94607
Attention: Washington Burns M.D.

Oakland Unified School District
Health Services
746 Grand Ave
Oakland, CA 94610
Attention: Barbara Parker, Coordinator, Health Services/ Section 504

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XVI. Health Insurance Portability and Accountability Act (HIPAA)

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), regulations have been promulgated governing the privacy and security of individually identifiable health information (IIHI) otherwise defined as Protected Health Information (PHI) or electronic Protected Health Information (ePHI). The HIPAA Privacy and Security Regulations specify requirements with respect to contracts between an entity covered under the HIPAA Privacy and Security Regulations and its Business Associates. A Business Associate is defined as a party that performs certain services on behalf of, or provides certain services for, a Covered Entity and, in conjunction therewith, gains access to IIHI, or PHI or ePHI. Therefore, in accordance with the HIPAA Privacy and Security Regulations, District shall comply with the terms and conditions as set forth in the attached Business Associate Agreement, hereby incorporated by this reference as Appendix I.

XVII. Entire Agreement:

This Agreement contains the final, complete and exclusive Agreement between the parties hereto. Any prior Agreement promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth herein are of no force or effect. This Agreement is executed without reliance upon any promise, warranty or representation by any party or any representative of any party other than those expressly contained herein. Each party has carefully read this Agreement and signs the same of its own free will.

XVIII. Authorization:

The undersigned individuals represent that they are fully authorized to execute this Agreement on behalf of the named parties.

IN WITNESS whereof, this Agreement has been executed by the parties hereto as of the day and year first written above.

/
/
/

Prescott-Joseph Center for Community Enhancement, Inc.

► Washington Rucker CEO
Director

Dated: 7/2/15

OAKLAND UNIFIED SCHOOL DISTRICT
Office of General Counsel
APPROVED FOR FORM & SUBSTANCE
By: _____
Attorney at Law

James Harris
President, Board of Education
9/25/15

The Oakland Unified School District

By: ► _____
(Authorized signature - sign in blue ink)

Name: Antwan Wilson
Antwan Wilson
Secretary, Board of Education
9/25/15

Title: Superintendent

Dated: _____

Address: 1000 Broadway, 6th floor
Oakland, CA 94607

Approved as to Legal Form	Reviewed by Contract Compliance	Presented to BOS for Signature
► _____	► _____	► _____
County Counsel		Department Head
Date _____	Date _____	Date _____

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Input Date	**Keyed By**

OUSD or the District verifies that the Contractor does not appear on the Excluded Parties List at https://www.sam.gov/

APPENDIX I

BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Agreement, DISTRICT, hereinafter referred to as BUSINESS ASSOCIATE, may use or disclose Protected Health Information to perform functions, activities or services for or on behalf of PJCCE, hereinafter referred to as the COVERED ENTITY, as specified in this Agreement and in the attached Contract, provided such use or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d et seq., and its implementing regulations, including but not limited to, 45 Code of Regulations Parts 160, 162, and 164, hereinafter referred to as the Privacy and Security Rules.

I. Obligations and Activities of Business Associate.

a. Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law. Business Associate shall disclose to its employees, subcontractors, agents, or other third parties, and request from Covered Entity, only the minimum Protected Health Information necessary to perform or fulfill a specific function required or permitted hereunder.

b. Business Associate shall implement administrative, physical, and technical safeguards to:
   1. Prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
   2. Reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

c. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate shall report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement and/or any security incident with respect to electronic Protected Health Information of which it becomes aware.

e. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, shall comply with the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate shall provide access to Protected Health Information in a Designated Record Set to Covered Entity or to an Individual, at the request or direction of Covered Entity and in the time and manner designated by the Covered Entity, in order to meet the requirements of 45 CFR 164.524.

g. Business Associate shall make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526, in the time and manner designated by the Covered Entity.

h. Business Associate shall make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, and/or to the Secretary for the U.S. Department of Health and Human Services, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules.

i. Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

j. Business Associate shall provide to Covered Entity or an Individual, in the time and manner designated by the Covered Entity, information collected in accordance with provision (i), above, to permit Covered Entity to respond to a request by the Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

k. Upon termination of this Agreement, Business Associate shall return all Protected Health Information required to be retained and return or destroy all other Protected Health Information received from the Covered Entity, or created or received by the Business Associate or its subcontractors, employees or agents on behalf of the Covered Entity. In the event the Business Associate determines that returning the Protected Health Information is not feasible, the Business Associate shall provide the Covered Entity with written notification of the conditions that make return not feasible. Business Associate further agrees to extend any and all protections, limitations, and restrictions contained in this Agreement, to any Protected Health Information retained by Business Associate or its subcontractors, employees or agents after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible.

II. Specific Use and Disclosure Provisions.

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation service to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR 164.502(j)(1).

III. Obligations of Covered Entity.

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

IV. General Provisions.

a. Remedies. Business Associate agrees that Covered Entity shall be entitled to seek immediate injunctive relief as well as to exercise all other rights and remedies which Covered Entity may have at law or in equity in the event of an unauthorized use or disclosure of Protected Health Information by Business Associate or any agent or subcontractor of Business Associate that received Protected Health Information from Business Associate.

b. Ownership. The Protected Health Information shall be and remain the property of the Covered Entity. Business Associate agrees that it acquires no title or rights to the Protected Health Information.

c. Regulatory References. A reference in this Agreement to a section in the Privacy or Security Rule means the section as in effect or as amended.

d. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

e. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 5/5/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Kym Hayward
BayRisk Insurance Brokers Inc. 1920 Minturn Street P.O. Box 567 Alameda CA 94501-9667	PHONE (A/C, No, Ext): (510) 523-3435 FAX (A/C, No): (510) 523-1632 E-MAIL ADDRESS: kym@bayrisk.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Travelers Indemnity Co of CT	25682
INSURER B: Travelers P&C Ins Company	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Prescott-Joseph Center for Community Enhancement
920 Peralta Street
Oakland CA 94607

COVERAGES **CERTIFICATE NUMBER:** 15/16 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [ ] OCCUR [X] GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:			660-406X283A-TCT-15	4/14/2015	4/14/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS [ ] SCHEDULED AUTOS X HIRED AUTOS [X] NON-OWNED AUTOS			660-406X283A-TCT-15	4/14/2015	4/14/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED X RETENTION $ 10,000			CUP3956T67915	4/14/2015	4/14/2016	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	Social Services Professional Liability			660-406X283A-TCT-15	4/14/2015	4/14/2016	$2,000,000 $1,000,000	Aggregate Per Claim

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Oakland Unified School District, its Board, officers and employees are named as additional insured as respects to General Liability for grant to the named insured and is subject to the policy terms, conditions and exclusions. Sexual Abuse Coverage is included in the policy, Retroactive Date: 4/14/97. *Policy Cancellation Exception: 10 days for non-payment of premium.

CERTIFICATE HOLDER

Oakland Unified School District
Attention: Risk Management
900 High Street
Oakland, CA 94601

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Kym Hayward/KYM

Kym C Hayward

Northern California Breathmobile®

A Project of the Prescott-Joseph Center

Patient Medical Information and Consent

Student Name _____ Date of Birth____/____/_____

School _____ Grade _____

Parent's Name: _____Phone (home)_____Cell _____

Home Address_____

Emergency Contact _____ Phone_____

Primary Care Physician _____ Clinic_____

Address_____

Does the patient have Medi-Cal (Alliance or Blue Cross)? YES or NO

Please give Patient's Medi-Cal/Insurance ID # _____

OR Social Security # _____

To be used for prior Authorization purposes

Does your child have any of the following medical conditions?

Asthma Diabetes Seizures Allergies Other _____

Please List Current Asthma medications:

Daily controller Medication _____How often? _____

Quick Relief (Rescue) Inhaler _____How Often?_____

List all other medications here: _____

_____

Parental Consent for Medical Treatment on the Breathmobile

This consent serves as permission for evaluation, diagnosis, and treatment of asthma by the Breathmobile® medical staff. I understand all services are free of charge. I authorize the school nurse, Breathmobile® medical staff and any other trained school personnel to consult with my child's Health Care Provider about my child's medical needs as necessary. The Breathmobile® program has permission to release my child's medical records to any hospital where my child is admitted and/or child's provider. I may revoke part or all of this consent at any time by providing revocation in writing to the Breathmobile.

Parent/Guardian Signature _____Date _____

Northern California Breathmobile®

Un proyecto del Prescott-Joseph Center

Información Médica del Paciente y Consentimiento

Nombre del Estudiante_____ _____Fecha de Nac.____/____/_____

Escuela _____ Grado_____

Nombre de Padre/Madre/Guardián: _____

Numero de Teléfono de casa _____Móvil_____

Domicilo _____ _____

Contacto de Emergencia_ _ _____ Teléfono_____

Proveedor de Cuidado Médico del Estudiante_____ _____

Dirección del Proveedor_____ _____

¿El estudiante tiene Medi-Cal (Alliance o Blue Cross)? SI or NO

El número de tarjeta de Medi-Cal/Seguro Médico

_____

O Número de Seguro Social_____

Para ser utilizado para los propósitos de autorización previa

¿Su hijo(a) padece de algunas de estas condiciones médicas?

Asma Diabetes Convulsiones Alergias Otro __ _____

Medicación actual del asma:

Medicamento controlador_ _____ _____¿Con qué frecuencia la usa ? _____

Inhalador de alivio rápido _____¿Con qué frecuencia la usa ? _____

Otro medicamento:_____ _____

_____ _____

Consentimiento de los Padres para recibir tratamiento médico en el Breathmobile

Este consentimiento sirve como permiso para evaluar, diagnosticar, y tratar el asma de mi hijo(a) por los empleados médicos del Breathmobile®. Comprendo que todos los servicios son gratuitos. Autorizo a la enfermera de la escuela, empleados entrenados de la escuela, y/o empleados del Brethmobile® a consultar con el proveedor de cuidado médico de mi hijo(a) como sea necesario. El Programa del Brethmobile® tiene permiso de presenter los documentos médicos de mi hijo(a) a cualquier hospital donde mi hijo(a) sea ingresado(a) y/o al proveedor. Puedo revocar parte o todo de este consentimiento en cualquier momento proporcionando la revocación por escrito al Breathmobile.

Firma de Padre Madre Guardián_ _____ Date_ _____

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

For___Prescott-Joseph Center for Community Enhancement and The Breathmobile of Northern California ("the organization")

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the organization may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the organization's duties and contact information.

I. Protected Health Information

"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations

Your protected health information may be used and disclosed by the organization in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The organization may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The organization may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the organization may coordinate your health care with a third party. For example, the organization may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots which we prepared. In addition, the organization may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

Payment. If reimbursement is sought from your health insurer for services received from the Breathmobile, your protected health information may be disclosed. Such disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. The organization may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care for which you seek reimbursement. Finally, the organization may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations. The organization may use or disclose your protected health information when needed for the organization's health care operations for the purposes of management or administration of the organization and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the organization may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the organization may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, the organization may also use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

II. Additional Uses and Disclosures Permitted Without Authorization or An Opportunity to Object

In addition to treatment, payment, and health care operations, the organization may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The organization will comply with any Federal, state or local law that requires it to disclose your protected health information.

When There Are Risks to Public Health. The organization may disclose your protected health information for public health purposes, including to, as permitted or required by law:

(1)Prevent, control, or report disease, injury, or disability;

(2) Report vital events such as birth or death;

(3) Conduct public health surveillance, investigations, and interventions;

(4) Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;

(5) Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
(6) Report to an employer information about an individual who is a member of the workforce.

To Report Abuse, Neglect Or Domestic Violence. As required or authorized by law or with the patient's agreement, the organization may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence.

To Conduct Health Oversight Activities. The organization may disclose your protected health information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions; (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the organization will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

For Judicial And Administrative Proceedings. The organization may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided.

For Law Enforcement Purposes. The organization may disclose your protected health information to a law enforcement official for law enforcement purposes when:
(1) Required by law to report of certain types of physical injuries;
(2) Required by court order, court-ordered warrant, subpoena, summons or similar process;
(3)Needed to identify or locate a suspect, fugitive, material witness or missing person;
(4) Needed to report a crime in an emergency situation.
(5) You are the victim of a crime in specific limited instances; and
(6) Your death is suspected by the practice to be the result of criminal conduct.

To Coroners, Funeral Directors, and for Organ Donation. The organization may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, or (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the organization may disclose protected health information, including when death is reasonably anticipated, to a funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

To Prevent or Diminish A Serious and Imminent Threat To Health Or Safety. If in good faith the organization believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct.

For Specified Government Functions. As authorized by the HIPAA privacy regulations, the organization may use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The organization may disclose your protected health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted With An Opportunity to Object

Subject to your objection, the organization may disclose your protected health information (1) to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The organization will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the organization is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care, then the organization may disclose your protected health information. If you are incapacitated or in an emergency situation, the organization may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

IV. Uses and Disclosures Authorized by You

Other than the circumstances described above, the organization will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

V. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the organization holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the practice uses to make decisions regarding the services provided to you. The organization may deny your request to inspect or copy your protected health information if the organization determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information.

You have the right to request a review of this decision. In addition, you may not inspect or copy certain records by law, including: (1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the organization's Privacy Officer to inspect and copy your health information. The organization may charge you a fee for the costs of copying, mailing, or other costs incurred by the organization in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record at the number given on the last pages of this Notice.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the organization not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the organization not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the organization's Privacy Officer.

The organization may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the organization agrees to the requested restriction, the organization may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The organization may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the practice by alternative means or at an alternative location. You have the right to request that the organization communicates with you through alternative means or at an alternative location. The organization will make every effort to comply with reasonable requests. However, the organization may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information.

During the time that the organization holds your protected health information, you may request an amendment of your information in a designated record set. The organization may deny your request in some instances. However, should the organization deny your request for amendment, you have the right to file a statement of disagreement with the organization. In turn, the organization may develop a rebuttal to your statement. If it does so, the organization will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the organization's disclosures of your protected health information made for purposes other than treatment, payment or health care operations as described in this Notice. The organization is not required to account for disclosures (1) which you requested, (2) which you authorized by signing an authorization form, (3) for a facility directory, (4) to friends or family members involved in your care, and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six year period. The organization is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The organization will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the reasonable costs for compliance of the request.

The right to obtain a paper copy of this Notice. The organization will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VI. The Organization's Duties

The organization is required to ensure the privacy of your health information and to provide you with this Notice of your rights and the organization's duties and procedures regarding your privacy. The organization must abide by the terms of this Notice, as may be amended periodically. The organization reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the organization collects and maintains. If the organization alters its Notice, the practice will provide a copy of the revised Notice through regular mail or in-person contact.

VII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the organization and to the Secretary of the Department of Health and Human Services. You may provide complaints to the organization verbally or in writing. Such complaints should be directed to the Privacy Officer. The organization encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the organization should be directed to the Privacy Officer at the following address:

920 Peralta St.
Oakland, CA 94607

ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at _510-208-5651_____

IX. Effective Date

This Notice is effective on July 30, 2010

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

ACKNOWLEDGEMENT

I, _____ (patient or patient's parent/guardian), acknowledge that I have received a copy of _The Breathmobiles's Notice Regarding Privacy of Personal Health Information.

Signature_____Date_____

(Patient's Signature or Parent/Guardian's Signature if patient is a minor)

Patient Name_____ ____ Date of Birth _____
Address_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution:_____
Address_____City_____State_____Zip_____

TO: Person/Institution: **Northern California Breathmobile**
Address: **920 Peralta Street, Oakland CA 94607** Fax: **510-208-3195**

Purpose or need for Information:_____

Disclosure will include: (check all that apply)

History & Physical Lab Report Allergy Testing results Discharge Summary ER report Physician Notes
Xray/Radiology Nurses Notes Consultation Report Other_____

Records for the period (dates) from _____ to _____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____ _____
Signature of Patient/Parent/Legal Guardian relationship to patient Date

_____ _____
Witness Date

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Northern California Breathmobile
920 Peralta Street Oakland CA 94607
Phone: 510-763-1880

Permission for Child to be seen With Someone other than Parent

When I am unavailable to attend appointments with my child, _____,

I give permission for _____ to bring my child to the Breathmobile

for their appointment. This person has permission to make medical decisions for my child. I have filled

out the medical information sheet and HRA survey. (to be sent with person bringing child).

If you have any further questions, I can be reached at the following phone number _____.

_____

Print Name of Parent

_____ _____

Signature of parent Date

*I may revoke this permission at anytime by providing a letter to the Breathmobile, or with a verbal Consent.

Northern California Breathmobile
920 Peralta Street Oakland CA 94607
Phone: 510-763-1880

El permiso para que otro adulto que no sean los padres puede acompañar el niño

Cuando no estoy disponible para asistir a las citas con mi hijo/a, _____,

Doy permiso para que _____ pueda llevar a mi hijo/a al Breathmobile para su cita. Esta persona tiene permiso para tomar decisiones médicas por mi hijo/a.

He llenado la hoja de información médica y el cuestionario de HRA. (para ser enviados con persona que traiga a mi niño/a).

Si usted tiene alguna duda, puedo ser alcanzado en el siguiente número de teléfono _____.

_____

Nombre del Padre

_____ _____

Firma del padre Fecha

* Puedo revocar este permiso en cualquier momento por medio de una carta a la Breathmobile, o con el consentimiento verbal.

Northern California BREATHMOBILE®
HRA Core Question Set Survey

Section 1

Survey Date ___ ___/___ ___/___ ___

1) Demographic Information: First name_____ _____ _____ _____ _____ Last Name_____ _____ _____ _____ DOB___/___/___
Gender: ☐Male ☐Female

2) What is your ethnic background (select one): ☐American Indian or Alaskan Native ☐Arab or Arab American ☐Asian or Asian American ☐Black or African American ☐Hispanic or Latino ☐Indian or Southeast Asian ☐Pacific Islander or Hawaiian ☐White (not Hispanic)
Other_____ _____ _____ _____ _____

3) Have you ever been diagnosed with Asthma by a physician? ☐Yes ☐No

4) Have you ever been diagnosed with Diabetes by a physician? ☐Yes ☐No Does Diabetes run in your family? ☐Yes ☐No

Section 2

1) During the past year, have you had repeated episodes of any of the following health conditions? Asthma ☐Yes ☐No Cough ☐Yes ☐No Chest Tightness ☐Yes ☐No Trouble Breathing ☐Yes ☐No Wheezing ☐Yes ☐No Bronchitis ☐Yes ☐No

2) During the past years, how often have you been treated in a ☐ emergency room or ☐ hospital (over night) for episodes of cough, chest tightness, trouble breathing or wheezing? ☐Never ☐One time ☐Two times ☐Three times ☐Four times ☐Five times or more

3) In the past year, how often have you missed school or work because of cough, chest tightness, trouble breathing, or wheezing?
☐Never ☐1day ☐2 days ☐3 days ☐4 days ☐5 days or more

4) Do you have episodes of cough, chest tightness, trouble breathing, or wheezing when you play or exercise? ☐Never ☐Rarely ☐Sometimes ☐Often ☐Most of the time

5) In the past 4 weeks, how often have you used a medicine (a syrup, an inhaler, or a breathing machine) to treat episodes of cough, chest tightness, trouble breathing or wheezing? ☐Never ☐Less than 2 days a week ☐Two or more days a week but not everyday ☐Everyday ☐More than once a day on most days

6) In the past 4 weeks, how often have you had episodes of cough, chest tightness, trouble breathing, or wheezing in the morning or during the daytime? ☐Never ☐Less than two days a week ☐Two or more days a week but not everyday ☐Everyday ☐More than once a day

7) During the past 4 weeks, how often have you had episodes of cough, chest tightness, or wheezing in the night or while sleeping? ☐Never ☐Less than one night a week ☐One night a week or more but not every night ☐Every night

Section 3

1) How many days per week do you take your controller medications ☐Never ☐One day a week ☐Two days a week ☐Three days a week ☐Four days a week ☐Five days a week ☐Six days a week ☐Everyday ☐Not sure

2) Do you have repeated episodes of any of the following health conditions? Rubbing or itching of the nose ☐Yes ☐No Stuffy or blocked nose ☐Yes ☐No Runny nose ☐Yes ☐No Clearing of the throat ☐Yes ☐No Snoring or mouth breathing at night ☐Yes ☐No

Northern California Breathmobile®
El cuestionario de HRA

Sección 1

Fecha de hoy _____/_____/_____

1) Información demográfica: Primer Nombre_____ Apellido_____

Fecha de Nacimiento _____/_____/_____ Género: ☐Hombre ☐Mujer

2) ¿Cuál es su origen étnico (elegir uno): ☐Indio Americano o Alaska Nativo ☐Árabe o Árabe Americano ☐Asiático o Asiático Americano ☐Hispano o Latino ☐Indio o Asiático Sureste ☐Isleño Pacifico ☐Blanco (No Hispano)
otro _____

3) ¿Se le ha diagnosticado un médico con Asma? ☐Sí ☐No

4) ¿Se le ha diagnosticado un médico con Diabetes? ☐ Sí ☐No ¿Hay un historia de Diabetes in su familia? ☐Sí ☐No

Sección 2

1) ¿Durante el año pasado, ha tenido episodios repetidos de los siguientes condiciones de salud? Asma ☐Si ☐No Tos ☐Si ☐No Pecho Apretado ☐Si ☐No Problemas de Respirar ☐Si ☐No Sibilancia ☐Si ☐No Bronquitis ☐Si ☐No

2) ¿Durante los año pasados, le han dado tratamiento en el hospital de emergencia para episodios de: Tos, Pecho Apretado, Problemas de Respirar o Sibilancia? ☐Nunca ☐Una vez ☐ Dos veces ☐Tres veces ☐Cuatro veces ☐Cinco veces o mas

3) ¿Durante el año pasado, cuanto tiempo ha perdido en la escuela o trabajo debido a: Tos, Pecho Apretado, Problemas de Respirar o Sibilancia? ☐Nunca ☐Un día ☐ Dos días ☐Tres días ☐Cuatro días ☐ Cinco días o más

4) ¿Ha tenido episodios de Tos, Pecho Apretado, Problemas de Respirar o Sibilancia cuando juegues o haces ejercicio? ☐Nunca ☐Raras Veces ☐A Veces ☐Frecuentemente

5) ¿Durante las 4 semanas pasados, cuantas veces ha usado medicinas como (almíbar, un inhalador o maquina de respirar) para tratamiento de: Tos, Pecho Apretado, Problemas de Respirar o Sibilancia? ☐Nunca ☐Menos de dos días a la semana ☐Dos días o más a la semana, pero no cada Día ☐Cada Día ☐Más que una vez al día

6) ¿Durante los 4 semanas pasados, cuantas veces ha tenido episodios de: Tos, Pecho Apretado, Problemas de Respirar o Sibilancia en la mañana o durante el día? ☐Nunca ☐Menos de dos días a la semana ☐Dos días o más a la semana, pero no cada día ☐Cada Día Más que una vez al día

7) ¿Durante los 4 semanas pasados, cuantas veces ha tenido episodios de Tos, Pecho Apretado, Problemas de Respirar o Sibilancia en la noche o mientras que está dormido? ☐Nunca ☐Menos que una noche a la semana ☐Una noche a la semana o más pero no cada noche ☐Cada Noche

Sección 3

1) ¿Cuántas días a la semana usas el medicamento de control? ☐Nunca ☐Un día a la semana ☐Dos días a la semana ☐Tres días a la semana ☐Cuatro días a la semana ☐Cinco días a la semana ☐Seis días a la semana ☐Cada día ☐No estoy seguro

2) ¿Tiene episodios repetidos en las siguientes condiciones de salud? Comezón de la nariz ☐Si ☐No Nariz Tapada ☐Si ☐No Desecho de la Nariz ☐Si ☐No Carraspear la Garganta ☐Si ☐No Roncar de Noche ☐Si ☐No

Medical History

Name of child: _____

Date of Birth: _____

At what age was your child diagnosed with asthma? _____

Was your child delivered full term or premature? _____

How many times has your child been seen in the ER for asthma? _____ Hospitalizations? _____

Has your child ever been prescribed prednisone or prednisolone for severe asthma attacks? Y or N If yes, how long was he/she on it? _____ How many times have they had to use it? _____

How many days has your child missed from school due to asthma? _____

Which of the following are triggers for your child's asthma? (check all that apply)

□ airborne chemicals (bleach, cleaning solutions) □ animals _____ □ Pollen □Smoke □Dust Mites

□Cold weather □Stress □Upper respiratory infections (colds/Viruses) □Strong odors/perfume □Exercise

When are his/her symptoms worse?

□ Morning □Evening □Bedtime □Lying down □On wakening □With illness □With Exercise

Family History: (check all that apply)

□ Nasal or eye Allergies □Asthma □ Cystic fibrosis □ Eczema □ Diabetes

□ Child adopted, history unknown

Please Check symptoms that your child is currently experiencing:

□ Asthma □ Rapid breathing □ Chronic cough □ Shortness of breath □ Wheezing □ Ear infection/pain

□ Excessive thirst □ Excessive hunger □ Eye discharge □ Nasal congestion □ runny nose □ Sneezing

□Throat clearing □ sore throat □ seasonal allergies □ itchy eyes □ Hives □ Rash/eczema

Home Environment:

Do beds have allergy incasings on them? _____

Do you live in a house or apartment? _____

Do you have hardwood floors or carpeting? _____

Are there stuffed animals, books, throw pillows in your child's room? _____

Any damp, moldy areas in house? □Yes □No

Infestation with: □ Mice □ Rats □Cockroaches

Any animals in the home? □Yes □ No If yes, what type of animal? _____

Current medications

_____

_____

_____

Historia Médica

Nombre de hijo/a: _____

Fecha de nacimiento: _____

¿A qué edad fue su hijo/a diagnosticado con el asma? _____

¿Su hijo/a nació a término o prematuro? _____

¿Cuántas veces se ha visto a su hijo/a en la sala de emergencias para el asma? _____ ¿Hospitalizaciones? _____

¿Le han recetado a su hijo/a el medicamento prednisona o prednisolona para los ataques graves de asma? Sí o No. En caso afirmativo, ¿cuánto tiempo tuvo que tomarlo? _____ ¿Cuántas veces tuvieron que utilizarlo? _____

¿Cuántos días ha perdido a su hijo de la escuela debido al asma? _____

¿Cuál de los siguientes son factores desencadenantes de asma de su hijo/a? (Marque todo lo que corresponda)

□ químicos en el aire (lejía, soluciones de limpieza) □ animales _____ □ Los ácaros del polvo □ Polen □ Humo
□ El clima frío □ Estrés □ Infecciones respiratorias superiores (resfriados / virus) □ Olores fuertes / perfume □ Ejercicio

¿Cuándo son sus síntomas peor?

□ Mañana □ Tarde □ Al acostarse □ Al despertar □Con enfermedad □Con ejercicio

Historia Familiar: (marque todo lo que corresponda)

□ Alergia nasal e ocular □ Asma □ Fibrosis quística □ Eczema □ Diabetes
□ Niño/a adoptado, historia desconocida

Por favor, marque los síntomas que su hijo/a está experimentando actualmente:

□ Asma □ Respiración rápida □Tos crónica □Dificultad para respirar □ sibilancias □infección del oído / dolor
□ Sed excesiva □ Hambre excesiva □ Secreción de ojo □ Secreción nasal □ Estornudos □ Aclarar la garganta o dolor de garganta □ Alergias □Picazón en los ojos □ Urticaria □Erupción / eczema

Ambiente en el hogar:

¿Las camas tienen sabanas antialérgicas en ellas? _____

¿Vive usted en una casa o apartamento? _____

¿Tiene pisos de madera o alfombra? _____

¿Hay animales de peluche, libros, almohadas en la habitación de su hijo/a? _____

¿Cualquier áreas húmedas, con moho en la casa? □ Sí □ No

La infestación con: □Ratones □ Cucarachas□ Ratas

¿Hay animales en la casa? □ Sí □ No En caso afirmativo, ¿qué tipo de animal? _____

Medicamentos actuales

_____

_____

_____

Northern California Breathmobile
920 Peralta Street
Oakland, CA 94607

Medication Information Sheet

My Child, _____ currently takes the following medications:

Name of Medication & Strength	How often is this medication used per week

Does your child have food allergies? Yes or No

If yes, to what foods is he/she allergic to and what happens when this food is eaten?

_____
_____
_____
_____

Does He/She have allergies to medications? Yes or No

If yes, what medications is he/she allergic to and what happens when he/she takes it?

_____
_____
_____
_____

Northern California Breathmobile
920 Peralta Street
Oakland, CA 94607

Hoja de Información de Medicamentos

Mi Hija/o, _____ actualmente toma los siguientes medicamentos:

Nombre del Medicamento y fuerza	¿Con qué frecuencia se usa este medicamento por semana?

¿Su hijo tiene alergias a los alimentos? Sí o no

En caso de sí, ¿a qué alimentos es él / ella alérgico? ¿ Y qué sucede cuando come este alimento?

_____

_____

_____

_____

¿Él / ella tiene alergias a medicamentos? Sí o no

En caso de sí, ¿a qué medicamentos es él / ella alérgico? ¿Y qué sucede cuando él / ella lo toma?

_____

_____

_____

_____

Logros

Los estudios de evaluación han demostrado que los pacientes tratados en el Breathmobile ® que su salud ha mejorado dramaticamente. Esto incluye:

- Menos visitas a urgencias y hospitalizaciones
- Mejora de la función pulmonar
- Disminución del ausentismo escolar
- Mejor calidad de vida

El programa Breathmobile ® ha demostrado que la atención especializada constante mantiene a los niños "en" la escuela y "fuera" de la sala de emergencias.

Acerca de Prescott-Joseph Center

Fundada en 1995, nuestra misión es triple:

1) Promover la autoestima individual de los ciudadanos en la comunidad a través de la educación, la formación profesional y los programas culturales, apoyando así las familias sanas y autosuficiencia económica,
2) Promover el sobre –salir renovación del espíritu de comunidad entre los residentes de West Oakland
3) Organizar y promover actividades comunitarias que faciliten el desarrollo económico y comunitario en West Oakland.

DATOS DE ASMA

- El asma es una de las tres principales causas de absentismo escolar entre los niños que representan más de 14 millones del total de días perdidos de escuela.
- Casi 5 millones de enfermos de asma son menores de 18 años.
- De los 58 condados de California, el Condado de Alameda tiene la segunda tasa de hospitalización más alta para el asma.
- En el Condado de Alameda, uno de cada cuatro niños de 5 a 17 son diagnosticados con asma.
- Entre 2004-2005, hubo más de 6.578 hospitalizaciones por asma en el Condado de Alameda.
- Los niños de W. Oakland tienen cinco veces más probabilidades de ser hospitalizados por asma que otros niños en California.
- Hay 22,000 personas que viven en West Oakland. De este número, el 25% de los niños y el 37% de los adultos tienen asma

RECURSOS:

- *Morbidity and Mortality Report, "National Center for Health Statistics (NCHA), U.S. CDC, 2003*
- *"The Cost of Asthma," Asthma & Allergy Foundation 1992 and 1998 Study, 2000 Update*

Asociados

Congresswoman Barbara Lee
* Port of Oakland
* Bay Area Air Quality Management District
* San Francisco Foundation
* California Wellness Foundation
* Oakland Unified School District
* Emeryville Unified School District
*San Leandro Unified School District
* Chevron

Prescott-Joseph Center
for Community Enhancement, Inc.

Orgullosamente sirviendo West Oakland y las comunidades circundantes

desde 1995!

Breathmobile ® del Norte de California

920 Peralta Street
Oakland, CA 94607
510-208-5651
510-208-3195 (Fax)
E-mail: info@prescottjoseph.org
Website: www.breathmobile-nca.org

Primer Breathmobile® En Norte California ~ Servir Escuelas en los condados de Alameda, Contra Costa Oeste, y San Francisco!

El Breathmobile ®

- El Breathmobile ® es una "clínica de asma en ruedas", patrocinado por el Prescott-Joseph Center. Provee el diagnóstico, educación, el tratamiento y los medicamentos para los niños con asma y las alergias, en sus escuelas. El Breathmobile® proporciona visitas periódicas de especialistas en asma a las escuelas.
- El primer Breathmobile ® fue lanzado en el sur de California el 16 de noviembre de 1995. En la actualidad hay nueve Breathmobiles ® en todo el sur de California que sirven cerca de 200 escuelas primarias, intermedias y secundarias.
- El Breathmobile ® también ha sido replicado en otras cuatro ciudades como Chicago, Phoenix, Baltimore, y Mobile, Alabama.

¿ Qué es El Breathmobile ® ?

- El asma es una de las tres principales razones de las ausencias escolares.
- El asma es la causa principal de las visitas de la infancia a la sala de emergencias.
- Más de 5,000 personas mueren de asma cada año en los Estados Unidos.

¿Cuál es el costo para visitar el Breathmobile ®?

En el Breathmobile®, pueden ver a los niños en sus escuelas sin ningún costo. Todos los servicios se ofrecen a las familias a:

¡NO COBRO!

Educación

- Educación para el paciente en el Breathmobile ® se centra en:
- El uso adecuado de los medicamentos, inhaladores de dosis medida, medidores de flujo máximo, dispositivos de separación, y tratamientos con el nebulizador.
- Medidas de control ambiental para interiores, disparadores.

Tratamiento

- El Breathmobile ® es similar al interior de la oficina de un doctor y tiene un alergista certificado, u otra especialista en el asma, la enfermera registrada y con licencia, terapeuta respiratorio, y un representante de servicios al paciente.
- La atención médica proporcionada en el Breathmobile ® incluye antecedents médicos y exámenes físicos, medicamentos gratuitos, espirometría y pruebas de la piel.

Accomplishments

Evaluation studies have demonstrated dramatic health improvements for patients treated on the Breathmobile ®. This includes:

- Fewer ER visits and hospitalizations
- Improved pulmonary function
- Decrease in school absenteeism
- Improved quality of life

The Breathmobile ® program has proven that consistent specialty care keeps children "in" school and "out" of the emergency room.

About the Prescott-Joseph Center

Founded in 1995, our mission is three-fold: 1) To promote the individual self-esteem of citizens in the community through education, skill training and cultural programs, thus supporting healthy families and economic self-sufficiency, 2) To promote the on-going renewal of community spirit among West Oakland residents and, 3) To organize and promote community activities that facilitate economic and community development in West Oakland.

ASTHMA FACTS

- Asthma is one of the three top causes of school absenteeism among children accounting for more than 14 million total missed days of
- Nearly 5 million asthma sufferers are under age 18.
- Of the 58 counties in California, Alameda County has the 2nd highest hospitalization rates for asthma.
- In Alameda County, one in four children ages 5-17 are diagnosed with asthma.
- Between 2004-2005, there were over 6,578 hospitalizations for asthma in Alameda County.
- W. Oakland children are five times more likely to be hospitalized for asthma than any other children in California.
- There are 22,000 people living in West Oakland. Of this number, 25% of the children and 37% of the adults have asthma

RESOURCES:

- *Morbidity and Mortality Report, "National Center for Health Statistics (NCHA), U.S. CDC, 2003*
- *"The Cost of Asthma," Asthma & Allergy Foundation 1992 and 1998 Study, 2000 Update*

Partners

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Prescott-Joseph Center

for Community Enhancement, Inc.

Proudly Serving West Oakland & Surrounding Communities since 1995!

Northern California Breathmobile ®

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Oakland, CA 94607
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510-208-3195 (Fax)
E-mail: info@prescottjoseph.org
Website: www.breathmobile-nca.org

Prescott-Joseph también provee servicios en Español

N. California's First Breathmobile ® ~ Serving Schools in Alameda, West Contra Costa, & San Francisco Counties!

The Breathmobile ®

- The Breathmobile ® is an "**asthma clinic on wheels**" sponsored by the Prescott-Joseph Center. It provides diagnosis, education, treatment, and medications to children with asthma and allergies at their school site. The Breathmobile ® provides regular visits of asthma specialists to schools.
- The first Breathmobile ® was launched in Southern California on November 16, 1995. There are now nine Breathmobiles ® throughout Southern California serving nearly 200 elementary, middle, and high schools.
- The Breathmobile ® has also been replicated in four other cities including Chicago, Phoenix, Baltimore, and Mobile, Alabama.

Why The Breathmobile ® ?

- Asthma is one of the three top reasons for school absences.
- Asthma is the leading cause of childhood visits to the emergency room.
- More than 5,000 people die from asthma each year in the United States.

What is the cost to visit the Breathmobile ®?

There is no cost for children to be seen on the Breathmobile ® at their school sites. All services are provided to families at:

NO CHARGE!

Patient/Family Education

Patient Education provided on the Breathmobile ® focuses on:

- Proper use of medications, metered dose inhalers, peak flow meters, spacing devices, and nebulizer treatments.
- Indoor environmental control measures, triggers.

Treatment

- The Breathmobile ® resembles the inside of a doctor's office and is staffed with a board-certified allergist, or other asthma specialist, licensed registered nurse, respiratory therapist, and a patient services representative.
- Medical care provided on the Breathmobile ® includes history and physical exams, free medications, spirometry, and skin testing.

SAM Search Results
List of records matching your search for :

Search Term : "Prescott-Joseph"Center* for* Community* Enhancement*
Record Status: Active

No Search Results

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

PROFESSIONAL SERVICES CONTRACT ROUTING FORM 2014-2015

Basic Directions

Additional directions and related documents are in the School Operations Library (http://intranet.ousd.k12.ca.us)

Services cannot be provided until the contract is fully approved and a Purchase Order has been issued.

1. Contractor and OUSD contract originator (principal or manager) reach agreement about scope of work and compensation.
2. Ensure contractor meets the consultant requirements (including The Excluded Party List, Insurance and HRSS Consultant Verification)
3. Contractor and OUSD contract originator complete the contract packet together and attach required attachments.
4. Within 2 weeks of creating the requisition the OUSD contract originator submits **complete** contract packet for approval to Procurement.

Attachment Checklist	
	☐ For individual consultants: HRSS Pre-Consultant Screening Letter for the current fiscal year.
	☐ For individual consultants: Proof of negative tuberculosis status within past 4 years.
	■ For All Consultants: Results page of the Excluded Party List (https://www.sam.gov/)
	■ For All Consultants: Statement of qualifications (organization); or resume (individual consultant).
	■ For All Consultants: Proof of Commercial General Liability insurance naming OUSD as an Additional Insured.
	■ For All Consultants with employees: Proof of Workers' Compensation Insurance. (Ref. to Section 10 of the Contract)

OUSD Staff Contact *Emails about this contract should be sent to:* **(required)** barbara.parker@ousd.k12.ca.us

Contractor Information

Contractor Name	Prescott-Joseph Center for Community Enhanc	Agency's Contact	Washington Burns, M.D.				
OUSD Vendor ID #	I004979	Title	Executive Director				
Street Address	920 Peralta Street	City	Oakland	State	CA	Zip	94607
Telephone	(510) 208-5651	Email **(required)**	WBurns691@aol.com				
Contractor History	Previously been an OUSD contractor? ■ Yes ☐ No		Worked as an OUSD employee? ☐ Yes ■ No				

Compensation and Terms – Must be within the OUSD Billing Guidelines

Anticipated start date	9/1/2015	Date work will end	6/30/2016	Other Expenses	
Pay Rate Per Hour **(required)**		Number of Hours **(required)**			

Budget Information

If you are planning to multi-fund a contract using LEP funds, please contact the State and Federal Office before completing requisition

Resource #	Resource Name	Org Key	Object Code	Amount
	No Fiscal Impact		5825	$ 0.00
			5825	
			5825	
Requisition No. **(required)**		**Total Contract Amount**		$ 0.00

Approval and Routing (in order of approval steps)

Services cannot be provided before the contract is fully approved and a Purchase Order is issued. Signing this document affirms that to your knowledge services were not provided before a PO was issued.

■ OUSD Administrator verifies that this vendor does not appear on the Excluded Parties List (https://www.sam.gov/)

1.	**Administrator / Manager** (Originator)	Name	Barbara Parker	Phone	273-1510
	Site / Department	968/ Health Services		Fax	273-1511
	Signature Barbara Parker			Date Approved	
2.	**Resource Manager,** if using funds managed by: ☐State and Federal ☐Quality, Community, School Development ☐Family, Schools, and Community Partnerships				
	☐Scope of work indicates compliant use of restricted resource and is in alignment with school site plan (SPSA)				
	Signature			Date Approved	
	Signature (if using multiple restricted resources)			Date Approved	
3.	**Regional Executive Officer**				
	☐Services described in the scope of work align with needs of department or school site ☐Consultant is qualified to provide services described in the scope of work				
	Signature Curtis Davis			Date Approved	8/15/2015
4.	**Deputy Superintendent Instructional Leadership / Deputy Superintendent Business Operations** Consultant Aggregate Under ☐, Over ☐$50,000				
	Signature			Date Approved	9/1/15
5.	**Superintendent, Board of Education** *Signature on the legal contract*				

Legal *Required if not using standard contract*		Approved		Denied - Reason		Date	
Procurement	Date Received			PO Number			

Rev. 6/2/14

THIS FORM IS NOT A CONTRACT