| Board Office Use: **Legislative File Info.** | |
|---|---|
| File ID Number | 16-1930 |
| Introduction Date | 9/28/16 |
| Enactment Number | 16-1536 |
| Enactment Date | 9/28/16 BR |

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)*

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

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**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, 2016 through June 30, 2017.

**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 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-two sites to be selected in conjunction with the Health Services Department for the period of September 1, 2016 through June 30, 2017, 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 Health Services Department for the period of September 1, 2016 through June 30, 2017.

**Fiscal Impact**

Funding Source: 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
Community Schools, Thriving Students

# CONTRACT JUSTIFICATION FORM
# This Form Shall Be Submitted to the Board Office With *Every* Consent Agenda Contract.

**Legislative File ID No.** 16-1930

**Department:** 968/Health Services

**Vendor Name:** Prescott -Joseph Center for Community Enhancement, Inc.

**Contract Term:** Start Date: 09/01/2016 End Date: 06/30/2017

**Annual Cost:** $ 0.00

**Approved by:** Barbara Parker

**Is Vendor a local Oakland business?** Yes ☑ No ☐

**Why was this Vendor selected?**

The Prescott-Joseph Center for Community Enhancement, Inc. operates a school-based mobile asthma treatment program referred to as the "Mobile Clinic". They will perform history and physical examinations, 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.

**Summarize the services this Vendor will be providing.**

Prescott-Joseph Center for Community Enhancement, Inc. will provide a school-based mobile asthma treatment program for students with asthma for up to twenty-two sites across the district, at no cost to the district.

**Was this contract competitively bid?** Yes ☐ No ☑

If No, answer the following:

1) How did you determine the price is competitive?

2) Please check the competitive bid exception relied upon:

- ☐ **Educational Materials**
- ☐ **Special Services** contracts for financial, economic, accounting, legal or administrative services
- ☐ **CUPCCAA exception** (Uniform Public Construction Cost Accounting Act)
- ☑ **Professional Service Agreements** of less than $87,800 (increases a small amount on January 1 of each year)
- ☐ **Construction related Professional Services** such as Architects, DSA Inspectors, Environmental Consultants and Construction Managers (require a "fair, competitive selection process)
- ☐ **Energy** conservation and alternative energy supply (e.g., solar, energy conservation, co-generation and alternate energy supply sources)
- ☐ **Emergency** contracts [requires Board resolution declaring an emergency]
- ☐ **Technology** contracts
  - ☐ electronic data-processing systems, supporting software and/or services (including copiers/printers) over the $87,800 bid limit, must be competitively advertised, but any one of the three lowest responsible bidders may be selected
  - ☐ contracts for computers, software, telecommunications equipment, microwave equipment, and other related electronic equipment and apparatus, including E-Rate solicitations, may be procured through an RFP process instead of a competitive, lowest price bid process
  - ☐ Western States Contracting Alliance Contracts (WSCA)
  - ☐ California Multiple Award Schedule Contracts (CMAS) [contracts are often used for the purchase of information technology and software]
- ☐ **Piggyback" Contracts** with other governmental entities
- ☐ **Perishable Food**
- ☐ **Sole Source**
- ☐ **Change Order for Material and Supplies** if the cost agreed upon in writing does not exceed ten percent of the original contract price
- ☐ **Other, please provide specific exception**

# 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

1000 Broadway, Suite 150 Oakland, CA 94607

Telephone — Federal ID No. or Social Security No.
510-879-2742

## 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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| ☐ Contract Database | ☐ FAS |
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| **Input Date** | **Keyed By** |
| | |

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:

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| **Input Date** | **Keyed By** |
| | |

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, 2017 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
1000 Broadway Suite 150
Oakland, CA 94607
Attention: Barbara Parker, Coordinator, Health Services/ Section 504

***Auditor/Controller-Recorder Use Only***

| ☐ Contract Database | ☐ FAS |
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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.

► _____
Director

Dated: 7/27/16

9/29/16
James Harris
President, Board of Education

The Oakland Unified School District

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

Name: Antwan Wilson

Title: Superintendent

Dated: 9/29/16

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

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

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

***Auditor/Controller-Recorder Use Only***

| ☐ Contract Database | ☐ FAS |
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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): 7/28/2016

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: Samatha Wheelock |
|---|---|
| Brown & Brown Insurance Services of CA, Inc<br>3697 Mt. Diablo Blvd #100<br><br>Lafayette CA 94549-3745 | PHONE (A/C, No, Ext): (510) 452-0458 FAX (A/C, No): (925) 297-2081<br>E-MAIL ADDRESS: swheelock@bbnca.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:** 16/17 GL BA UMB PROF **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<br>[ ] CLAIMS-MADE [X] OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>[X] POLICY [ ] PRO-JECT [ ] LOC<br>[ ] OTHER: | X | | 660-406X283A-TCT-16 | 4/14/2016 | 4/14/2017 | EACH OCCURRENCE<br>DAMAGE TO RENTED PREMISES (Ea occurrence)<br>MED EXP (Any one person)<br>PERSONAL & ADV INJURY<br>GENERAL AGGREGATE<br>PRODUCTS - COMP/OP AGG | $ 1,000,000<br>$ 100,000<br>$ 5,000<br>$ 1,000,000<br>$ 2,000,000<br>$ 2,000,000 |
| A | AUTOMOBILE LIABILITY<br>ANY AUTO<br>ALL OWNED AUTOS [ ] SCHEDULED AUTOS<br>[X] HIRED AUTOS [X] NON-OWNED AUTOS | | | 660-406X283A-TCT-16 | 4/14/2016 | 4/14/2017 | COMBINED SINGLE LIMIT (Ea accident)<br>BODILY INJURY (Per person)<br>BODILY INJURY (Per accident)<br>PROPERTY DAMAGE (Per accident) | $ 1,000,000<br>$<br>$<br>$ |
| B | [X] UMBRELLA LIAB [X] OCCUR<br>[ ] EXCESS LIAB [ ] CLAIMS-MADE<br>[ ] DED [X] RETENTION $ 10,000 | | | CUP3956T67916 | 4/14/2016 | 4/14/2017 | EACH OCCURRENCE<br>AGGREGATE | $ 3,000,000<br>$ 3,000,000 |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [ ]<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N/A | | | | | PER STATUTE [ ] OTH-ER<br>E.L. EACH ACCIDENT<br>E.L. DISEASE - EA EMPLOYEE<br>E.L. DISEASE - POLICY LIMIT | $<br>$<br>$ |
| A | | | | 660-406X283A-TCT-16 | 4/14/2016 | 4/14/2017 | | |

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
1000 Broadway, Suite 440
Oakland, CA 94607

**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

Denton Christner/SAM

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 7/28/2016

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: Samatha Wheelock |
|---|---|
| BayRisk Insurance Brokers,<br>A Brown & Brown Company<br>3697 Mt. Diablo Blvd #100<br>Lafayette CA 94549-3745 | PHONE (A/C, No, Ext): (510) 452-0458 FAX (A/C, No): (925) 297-2081<br>E-MAIL ADDRESS: swheelock@bbnca.com |

| INSURER(S) AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: State Compensation Ins. Fund | 35076 |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |
| INSURER F: | |

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

**COVERAGES** **CERTIFICATE NUMBER:** 16/17 WC **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 | |
|---|---|---|---|---|---|---|---|---|
| | COMMERCIAL GENERAL LIABILITY | | | | | | EACH OCCURRENCE | $ |
| | ☐ CLAIMS-MADE ☐ OCCUR | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ |
| | | | | | | | MED EXP (Any one person) | $ |
| | | | | | | | PERSONAL & ADV INJURY | $ |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | GENERAL AGGREGATE | $ |
| | ☐ POLICY ☐ PRO-JECT ☐ LOC | | | | | | PRODUCTS - COMP/OP AGG | $ |
| | ☐ OTHER: | | | | | | | $ |
| | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | ☐ ANY AUTO | | | | | | BODILY INJURY (Per person) | $ |
| | ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS | | | | | | BODILY INJURY (Per accident) | $ |
| | ☐ HIRED AUTOS ☐ NON-OWNED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | | $ |
| | ☐ UMBRELLA LIAB ☐ OCCUR | | | | | | EACH OCCURRENCE | $ |
| | ☐ EXCESS LIAB ☐ CLAIMS-MADE | | | | | | AGGREGATE | $ |
| | ☐ DED ☐ RETENTION $ | | | | | | | $ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH) N/A<br>If yes, describe under DESCRIPTION OF OPERATIONS below | | | 9132041-16 | 5/11/2016 | 5/11/2017 | ☐ PER STATUTE ☐ OTH-ER | |
| | | | | | | | E.L. EACH ACCIDENT | $ 1,000,000 |
| | | | | | | | E.L. DISEASE - EA EMPLOYEE | $ 1,000,000 |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | $ 1,000,000 |
| | | | | | | | | |

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

Certificate issued for insurance informational purposes only.

**CERTIFICATE HOLDER**

Oakland Unified School District
Attention: Risk Management
1000 Broadway, Suite 440
Oakland, CA 94607

**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

Denton Christner/SAM

*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_____

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 dia? ☐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

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?

_____
_____
_____
_____

## 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**

_____
_____
_____

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®*

*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_____

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

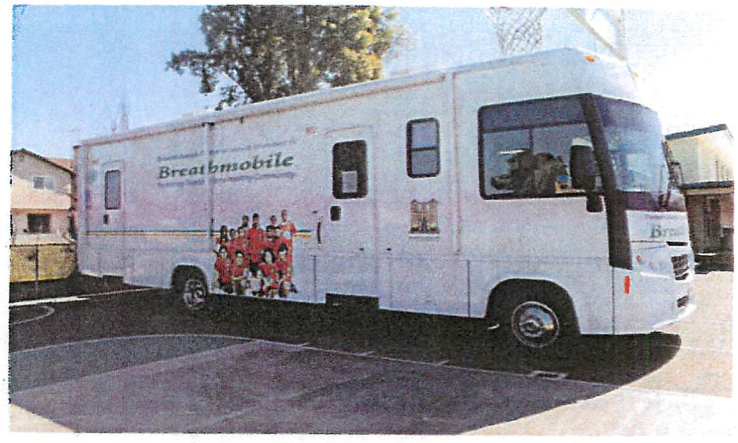
**REDISCLOSURE:** Notice is hereby given to the patient or legal representative signing this Authorization that Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that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

# Northern California Breathmobile ®

"Keeping kids in School and out of the ER"

**What we Offer:**

We provide **FREE** asthma treatment & education to children and their families at schools and community centers throughout Alameda, San Francisco and West Contra Costa counties.




## Does your Child have asthma?

## We Can help!!

**What is the Breathmobile®?**

The Breathmobile® is "an asthma clinic on wheels" with doctors, nurses, and staff that specialize in asthma. The clinic visits schools and community centers every 4-6 weeks. We provide the following services:

- Evaluation and treatment
- Education
- Medication (if available)
- Pulmonary testing
- Case Management

Not only do you get exceptional care, all our services are **FREE.**

**A parent or guardian must accompany the child for the appointments.**

**For more information or to schedule an appointment, please call the Breathmobile Office:**

**510-763-1880**

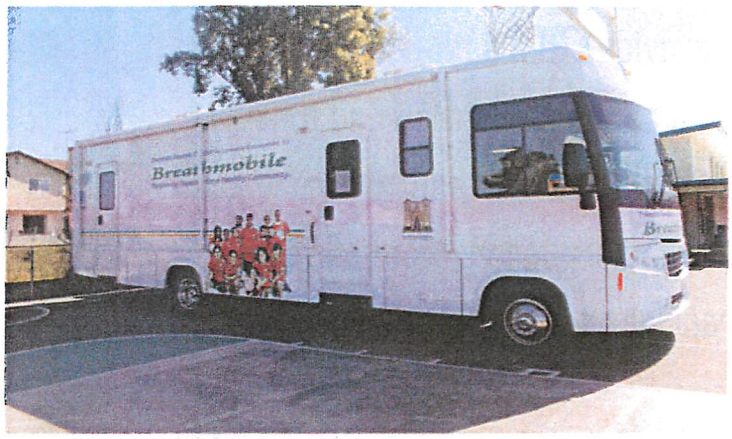
The Breathmobile is a project of the Prescott-Joseph Center for Community Enhancement.

# Northern California Breathmobile ®

"Mantener a los niños en la escuela y fuera de la sala de ER"

**Lo que ofrecemos:**

Ofrecemos tratamiento **gratis** para el asma y educación a los niños y sus familias en las escuelas y los centros comunitarios en los condados de Alameda, West Contra Costa y San Francisco




## ¿Tiene su hijo asma?

## ¡¡Podemos ayudarle!!

**¿Qué es el Breathmobile®?**

El Breathmobile® es "una clínica de asma en ruedas" con doctores de asma y enfermeros. La clínica visita a las escuelas y los centros comunitarios cada 4-6 semanas. Proveemos los siguientes servicios:

| | |
|---|---|
| Historiales de salud y exámenes físicos | Evaluaciones pulmonares |
| Tratamiento | Medicamentos (cuando sea disponible) |
| Educación | Mantenimiento de casos |

No sólo usted recibe atención médica excepcional, también nuestros servicios son **GRATUITOS**!!

**Un padre o guardián tiene que estar presente para las citas**

**Para más información o para hacer una cita, por favor de llamar a la oficina del Breathmobile: 510-763-1880**

Save Form | Print Form

# PROFESSIONAL SERVICES CONTRACT ROUTING FORM 2016-2017

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

## Basic Directions

*Additional directions and related documents are in the Knowledge Center on the Intranet and Contracts Online 2.0 Tool*

**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 Talent 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 All Consultants: Authorization to Work, which indicates vendor has cleared the registration and background check<br>☐ For All Consultants: Results page of the Excluded Party List (https://www.sam.gov/)<br>☐ For All Consultants: Statement of qualifications (organization); or resume (individual consultant). |
| **OUSD Staff Contact** *Emails about this contract should be sent to:* **(required)** | |

## Contractor Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Contractor Name | Prescott Joseph Center for Community Enhancer | 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 | 9/1/16 | Date work will end | 6/30/2017 | 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 | |
| | | | 5825 | |
| | | | 5825 | |
| **Requisition No.** **(required)** | n/a | **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 | 879-2742 |
| | Site/Department (Name & #) | 968/Health Services Department | | Fax | 879-4605 |
| | Signature | Barbara Parker | | Date Approved | 8/5/16 |
| 2. | **Resource Manager,** if using funds managed by: ☐ State and Federal ☐ Quality, Community, School Development ☐ Community Schools & Student Services ☐ Risk Mgmt | | | | |
| | ☐ Scope of work indicates compliant use of restricted resource and is in alignment with school site plan (CSSSP) | | | | |
| | Signature | | | Date Approved | |
| | Signature (if using multiple restricted resources) | | | Date Approved | |
| 3. | **Network Superintendent/Deputy Network Superintendent** | | | | |
| | Signature | | | Date Approved | |
| 4. | **Chiefs / Deputy Chiefs** Consultant Aggregate ☐ Under ☐ Over $_____ | | | | |
| | ☐ Services described in the scope of work align with needs of department or school site<br>☐ Consultant is qualified to provide services described in the scope of work | | | | |
| | Signature | | | Date Approved | |
| 5. | **Superintendent, Board of Education** *Signature on the legal contract* | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Legal** *Required if not using standard contract* | | Approved | | Denied - Reason | | Date | 9/6/16 |
| **Procurement** | Date Received | | | PO Number | | | |

Rev. 6/6/16

**THIS FORM IS NOT A CONTRACT**

**SAM Search Results**
**List of records matching your search for :**

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

| | | |
|---|---|---|
| ENTITY | PRESCOTT-JOSEPH CENTER FOR COMMUNITY ENHANCEMENT, INC. | Status:Active |
| DUNS: 843093639 | +4: | CAGE Code: 4R2X9 DoDAAC: |
| Expiration Date: Dec 3, 2016 | Has Active Exclusion?: No | Delinquent Federal Debt?: No |
| Address: 920 Peralta St<br>City: Oakland<br>ZIP Code: 94607-1926 | | State/Province: CALIFORNIA<br>Country: UNITED STATES |