|  |
| --- |
| School-Based Health Center & School Principal Collaborative Protocols  (Discussed and completed in joint meeting; updated annually School: [*Enter Name*] School Year: 2018-2019  |

**Principal*:*** [*Enter Name*]

**Principal’s Designated Liaison for SBHC:** [*Enter Name*] **& Contact Information**: [*Phone and office#*]

**SBHC Staff Present at Protocols Meeting:** [*Enter Names*]

**School Staff Present at Protocols Meeting**: [*Enter Names*]

**Enrollment Collaboration: *Ongoing enrollment/assistance with parental consent process throughout the year.***

| **Activities** | **Contact Person(s)** | **Notes**  |
| --- | --- | --- |
| * Inclusion of SBHC consent packet with school registration documents annually
 |  |  |
| * Designate central office point person to distribute and collect consents and work with the SBHC
 |  |  |
| * Robo Calls to the parents regarding enrolling their child in health Center
 |  |  |
| * Advertising of SBHC services throughout the school via posters and flyers throughout the campus
 |  |  |
| * Presentations in classroom to inform students about the SBHC services and consent process.
 |  |  |
| * Presentations of SBHC services at faculty meetings
* When is your professional development day scheduled
 |  | Work with \_\_\_\_\_\_\_\_\_\_\_\_\_ to be on the agenda on P.D. daysPD Day(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_PD Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Attendance at parent association meetings and orientations to speak about the SBHC
 |  | Work with parent, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for parent meetings |
| * Work with DOE LYFE program to ensure students who are parents are aware of SBHC services and are enrolled( if applicable )
 |  |  |

**Administrative Procedures: *Collaboration between the school and SBHC on shared forms, schedules, systems, procedure etc.***

| **Task/Systems**  | **School Contact Person(s)/Location** | **Procedure**  | **Notes** |
| --- | --- | --- | --- |
| * Access to student immunization information
 |  |  |  |
| * Access to student class schedules

 (Skedula) electronically or hard copy  |  |  |  |
| * Access to Blue Cards ( updated contact info and updated insurance info )
 |  |  |  |
| * Appointment Schedule System

(where the SBHC places the student appointment reminder slips within the schools) |  |  |  |
| * Passes for the SBHC Walk-In Visit

 (where do students get a pass to go to SBHC ) |  |  |  |
| * Recall of students to the SBHC (how to call down a student the SBHC needs to see immediately – who gets contacted in school )
 |  |  |  |
| * Health Center Closures
 |  |  |  |

**Emergency Procedures Collaboration: *School and SBHC working guidelines on notification of emergency situations and planning collaboratively to assure student wellness.***

| **Issue** | **Who in the school does the SBHC notify when the issue arises?** | **When (i.e., immediately, at regular meeting, etc.)** | **How do you notify the school (i.e., in person, telephone, etc.)/Notes** |
| --- | --- | --- | --- |
| **First Aid and Emergency Care: The provider must develop, in consultation with the principal, a plan to provide first aid and emergency care services to all students on campus whether or not the student is enrolled in the SBHC as per the NYCDOE MOU.**  |
| * Medical Provider Absence from SBHC
 |  | Immediately  |  |
| * Sick student (needing to go home from SBHC )
 |  | Immediately |  |
| * All DMAF/MAF/504 -Medications for students onsite ( All forms should be sent to the SBHC and they are responsible for the students care )
 |  | Immediately |  |
| * Epipen School Designee

 (as per chancellor regs) | List name of faculty/contact informationName :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | N/A |  |
| * CPR school Designee

(as per chancellor regs) | List name of faculty/contact informationName :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | N/A | Note the AED locations in the school buildings : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 911 Medical Emergency Situation

 (Who will accompany if parent not available). |  | Immediately |  |
| * Post Dismissal Emergency Situation
 |  | Immediately |  |
| * ACS Report made (Name of student and state central registry (SCR) # only)
 |  | Immediately |  |
| * Police Report made on student related to incident at school or related to school threat.
 |  | Immediately |  |
| * Inappropriate Behavior by Teacher or school staff (i.e., physical abuse, punishment, sexual abuse, or harassment)
 |  | Immediately |  |
| * Knowledge and/or rumor of planned fights/physical assaults in school/ on school premises
 |  | Immediately |  |
| * Knowledge or rumor of students carrying weapons or assaulting other students in school/on school premises
 |  | Immediately |  |
| * Drug Issues
	+ Student sale at school
	+ Staff member sale at school
 |  | Immediately |  |
| * Gang related activities/incidences at school/ school premises or a threat to the school.
 |  | Immediately  |  |
| * Suicide Emergency
	+ Attempt/serious plan needing transport to ER
	+ Who will accompany student if parent unavailable
 |  | Immediately |  |
| * Psychiatric Emergency needing a safety plan and transport to ER
* Who will accompany student if parent is unavailable
 |  | Immediately |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Principal [*Enter Name Here*] SBHC Manager/Administrator [*Enter Name Here*]

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SBHC Staffing Patterns: Attached please find the Staffing Grid for the current SBHC staff for this academic year.**

 **(**The SBHC must inform the principals and the Office of School Health of staffing changes as they occur)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **Staffing for the XXXXX(enter campus name) SBHC 2018-2019** |  |  |  |  |
| **Direct ServiceStaff** | **Name of Staff person** | **Lunch Hour**  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |  |  |  |  |
| **Hours Per Day** |  |  |  |  |
| Indicate hours worked (8-4, 8:30-4:30 etc.) |  |  |  |  |
| **Hours SBHC is open**  |   | x |   |   |   |   |   |  |  |  |  |
| **Front Desk Clerk/Receptionist**  |  |   |   |   |   |   |   |  |  |  |  |
| **Medical Assistant** |   |   |   |   |   |   |   |  |  |  |  |
| **Medical Assistant** |  |   |   |   |   |   |   |  |  |  |  |
| **NP/PA** |  |   |   |   |   |   |   |  |  |  |  |
| **NP/PA** |  |   |   |   |   |   |   |  |  |  |  |
| **Physician** |  |   |   |   |   |   |   |  |  |  |  |
| **RN/LPN**  |  |   |   |   |   |   |   |  |  |  |  |
| **Mental Health Provider** |   |   |   |   |   |   |   |  |  |  |  |
| **Mental Health Provider**  |   |   |   |   |   |   |   |  |  |  |  |
| **Health Educator**  |  |   |   |   |   |   |   |  |  |  |  |
| **Health Educator**  |  |   |   |   |   |   |   |  |  |  |  |
| **Other**  |  |  |  |  |  |  |  |  |  |  |  |
| **ADMINISTRATION:**  |  |   |  |  |   |   |   |  |  |  |  |
| **SBHC Program Manager/Administrator** |  |  |  |  |  |  |  |  |  |  |  |
| **SBHC Site Coordinator/Manager**  |  |   |   |   |   |   |   |  |  |  |  |
| **Medical Director**  |  |   |   |   |   |   |   |  |  |  |  |
| **Medical Supervisor**  |  |   |   |   |   |   |   |  |  |  |  |
| **Mental Health Director**  |   |   |   |   |   |   |   |  |  |  |  |
| **Mental Health Supervisor** |  |   |   |   |   |   |   |  |  |  |  |
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