NYC HEALTH+ HOSPITALS | Gotham Health

It's fast and easy for your child to receive health care services through the NYC Health + Hospitals / Gotham Health School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that your child's school – Manhattan Academy for Arts and Language, Success Academy High School of Liberal Arts, Murray Hill Academy, Unity Center for Urban Technologies – has a School Based Health Center (SBHC)! The SBHC is staffed by Renaissance, a Gotham Health Center, licensed professionals consisting of medical and mental health providers.

Please know that your child can use the School-Based Health Center and see your other doctors as well. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their primary doctor.

At the School Based Health Center, your child can receive the services listed below at **no cost** to you, regardless of insurance status. The SBHC is allowed to bill insurance, however there are **no co-pays for you**, and **you do not receive a bill.**

School Based Health Center Services include:

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions
- Age appropriate reproductive health care
- Health Education and Counseling
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Access to care 24 hours/day, 7 days/week

To register your child for the services of our School Based Health Center, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

☺ **Parental Consent Form**
☺ **HIPAA Authorization Form**

Give the completed forms to your principal's office or directly to the School Based Health Center in room 1025.

The School Based Health Center is located in room 1025 of your child's school and is open every school day between the hours of 8:00am-4:00pm.

We look forward to meeting you and we look forward to providing health services to your child. Feel free to visit us at the School Based Health Center in room 1025 or call us at 646-815-0730 for more information.

Sincerely,

Rhonda James-Rodney, Nurse Practitioner
Renaissance / Gotham Health

Mary McCord, MD, Pediatric Medical Director
NYC Health + Hospitals / Gotham Health

Siv Boletsis, Principal
Manhattan Academy for Arts and Language

Yvette Sy, Principal
Murray Hill Academy

Rachel Keane, Principal
Success Academy HS of Liberal Arts

Fausto de la Rosa, Principal
Unity Center for Urban Technologies

NYC Health + Hospitals | Gotham Health

School Based Health Center Parental Consent Form

111 East 33rd Street, Room 1025 New York, NY 10016

Please check off your child's school: [ ] Manhattan Academy for Arts
[ ] Murray Hill Academy [ ] Success Academy HS of Liberals Arts [ ] Unity Center for Urban Technologies

Please know that your child can use the School-Based Health Center and see your other doctors.
Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

STUDENT INFORMATION

Student Last Name: _____

Student First Name: _____

Date of Birth: ____/____/____ (Month / Day / Year)

Student Address: _____

_____ (City / State / Zip Code)

Student email: _____

***Student Social Security Number:** _____

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

List the student's regular doctor, if they have one?

Name: _____

Telephone: _____

Address: _____

Indicate the Pharmacy where we can send prescriptions.

Pharmacy _____

Pharmacy Address: _____

Pharmacy Tel: _____

***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

Parent/ Legal Guardian:

Last Name: _____ First Name: _____

Home/Work Tel: _____

Cell Phone: _____

Email: _____

Parent/Legal Guardian:

Last Name: _____ First Name: _____

Home/ Work Tel: _____

Cell Phone: _____

Email : _____

If legal guardian , relationship to the student:

❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: _____

Home /Work Tel: _____

Cell: _____

Email: _____

Preferred Language of Parent/ Guardian: _____

ADDITIONAL EMERGENCY CONTACT

Name: _____

Relationship to Student: _____

Home or Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have Child Health Plus?

❑ No ❑ Yes: CHP # _____

Which Plan?

❑ Affinity
❑ Fidelis
❑ Healthfirst
❑ Empire BC/BS Health Plus
❑ Emblem Health(HIP/GHI)
❑ Metro Plus
❑ WellCare
❑ United Healthcare

Does your child have other health insurance

❑ No ❑Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?

❑ No ❑ Yes, what is the best time to contact you? _____

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the NYC Health + Hospitals/Gotham Health School-Based Health Center. By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents, married or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

X _____ _____

Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in Box 2 on reverse side of this form. My signature indicates my consent to release medical information as specified in the box 2 section only.

X _____ _____

Signature of Parent/Guardian **Date**

NYC Health + Hospitals | Gotham Health

School Based Health Center Parental Consent Form

111 East 33rd Street, Room 1025 New York, NY 10016

SCHOOL BASED HEALTH CENTER SERVICES — BOX 1

I consent for my child to receive health care services provided by the State-licensed health professionals of NYC Health + Hospitals/Gotham Health as part of the school health program approved by the New York State Department of Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. For Adolescent Students: Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot), LARC, other FDA approved methods] testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Dental examinations including: diagnosis, treatment, and sealants where available.
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.

NEW YORK CITY DEPARTMENT OF EDUCATION'S FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION — BOX 2

My signature on the reverse side of this form authorizes release of medical information as specified below. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information as specified below to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the NYC Health + Hospitals/Gotham Health School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the School-Based Health Center to the NYC Department of Education and from the NYC Department of Education to the School-Based Health Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information Required by Law or Chancellor's Regulation including but not limited to:

* Comprehensive Physical Exam (Form CH-205 or Equivalent such as sports exams, etc.)
* Immunizations (required /recommended)
* Vision and hearing screening results
* Tuberculin test results

Information to Protect Health and Safety:

* Conditions which may require emergency medical treatment including chronic illness
* Conditions which limit a student's daily activity
* Diagnosis of certain communicable diseases (NOT including HIV infection/STI and other confidential services protected by law).
* Health insurance coverage
* Enrollment in School-Based Health Center
* Individualized Education Program (IEP)

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page **To:** Date that student is no longer enrolled in the SBHC

NOTE: This School Based Health Center Parental Consent Form has been approved by DOE/OSH

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School Based Health Center Health History Form

Student's Name: _____ Date of Birth: _____

Does your child have any allergies to medications or food? □ **Yes** □ **No**

Name of Medication (s): _____

Name of Food (s): _____

Does your child take any medication (s) daily? □**Yes** □**No**

Medication (s) and Dosage: _____

Does your child have a latex allergy? □Yes □No

Past Illnesses: Please check all past illnesses that your child has had:

□ Mumps	□Chicken Pox	□**Meningitis**	□Measles	□Tuberculosis
□**Rheumatic Fever**	□**Hepatitis**	□Mononucleosis	□Pneumonia	□Rubella
□**Urinary Tract Infections**	□Other Illness:			

Does your child have any health problems (past or present)? Please check any that you child has or had:

□ Anemia	□ Asthma	□ Behavioral Problems	□ Bone Problems
□ Bleedings	□ Cancer	□ Chest Pain	□ Constipation
□ Cystic Fibrosis	□ Dental Problems	□ Diabetes	□ Diarrhea
□ Dizziness/Fainting	□ Ear Infections	□ Emotional Problems	□ Frequent Colds/Coughs
□ Frequent Sore Throats	□ Headaches/Migraines	□ Hearing Problems	□ Heart Disease/Problems
□ Heart Murmur	□ High Blood Pressure	□ HIV	□ Intestinal Disease
□ Kidney Disease	□ Lead Poisoning	□ Liver Disease	□ Menstruation Problems
□ Overweight/Underweight	□ Sickle Disease/Trait	□ Skin Rashes	□ Shortness of Breath
□ Stomach Ache	□ Vision Problem	□Thyroid Problems	□ Others: _____

Hospitalization (s): Has your child ever been hospitalized? □Yes □No

Date	Name of Hospital	Reason
_____	_____	_____

Family Medical Problems: Does/did your child's relatives (alive/deceased) have any of the following medical problems?

Problem	Relation to child	Deceased	
□ Asthma	_____	Y	N
□ Diabetes	_____	Y	N
□ Heart Disease	_____	Y	N
□ Epilepsy	_____	Y	N
□ Tuberculosis	_____	Y	N
□ HIV/AIDS	_____	Y	N
□ High Blood Pressure	_____	Y	N
□Sudden Death	_____	Y	N

□ None

*Please tell us about any other concerns you may have regarding your child: _____

Signature: _____ Date: _____

NYC HEALTH+ HOSPITALS

HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION

Write Your Child's Doctor's Name Here:

SPECIFIC INFORMATION TO BE RELEASED: n/a

Information Requested:

- 1. Immunizations, Vision, Hearing & TB results; 2. Diagnosis of certain communicable diseases; 3. Chronic Illness Care; 4. New entrant exam (form CH-205)

Treatment Dates from Date Consent Signed to End of School Enrollment

NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT

NYC Health + Hospitals | Gotham Health
Norman Thomas School Based Health Center

INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). **Please note: unless all of the boxes are checked, we may be unable to process your request.**

- ☐ Alcohol and/or Substance Abuse Program Information
- ☐ Mental Health Information
- ☐ Genetic Testing Information
- ☐ HIV/AIDS-related Information

REASON FOR RELEASE OF INFORMATION

- ☐ Legal Matter
- ☐ Individual's Request
- ☒ Other (please specify): Coordination of Medical Care

WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)

- ☒ Event: End of school enrollment
- ☐ On this date: _____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE**, **GENETIC TESTING**, **MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYC Health + Hospitals cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYC Health + Hospitals has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If NYC Health + Hospitals has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

NYC HEALTH + HOSPITALS USE ONLY	
Date Received:	Initials of HIM Employee processing request:
Date Completed:	Comments: