Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

Montefiore School Health Program
http://www.montefiore.org/school-health-program

It's fast and easy
for your child to receive health care services through the Montefiore School-Based Health Center!

Dear Parent or Guardian:

We are happy to inform you that your child's school has a School Based Health Center (SBHC)! The SBHC is run by Montefiore Medical Center and is part of the Montefiore Medical Group. The SBHC is staffed by Montefiore Medical Center licensed professionals. This can include medical, mental health and dental providers.

Your child can use the School-Based Health Center and continue to see your other doctors. Signing this consent does not change your insurance, does not change your primary 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, but there are **no co-pays for you**, and **you should not receive a bill.**

School Based Health Center services include:

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests
- Immunizations / vaccines
- Medical care, including treatment for new 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
- After hours on-call providers
- Dental and vision services at some schools

To register your child for the services at our School Based Health Center, please:

1. Complete the attached **Consent form, Basic Health History and Insurance form.**

2. Attach the following documents
   - A copy of your child's insurance card(s) (front and back)
   - A copy of your child's immunization record

Be sure to sign the Parental Consent form in two places.

Take the completed forms to the Main Office at your child's school or directly to the School Based Health Center. The School Based Health Center is open every school day between the hours of 8:00 am – 3:30 pm.

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 for more information, or to call us with questions.

Sincerely,

Delaney Gracy, MD MPH
Director of Clinical Services

Grace Walfall, MBA
Senior Director of Operations

Montefiore School Health Program
School Based Health Center Parental Consent Form

School _____

Source
___In-classroom presentation
___Phone Call
___Orientation/Bridge Prog.
School-wide programs
___School Registration
___Parent engagement
___Student engagement

Date Received: _____

For office use only

OSIS# _____ ***Medical Record # (MRN)***_____

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:** _____
❑ Male ❑ Female Grade _____
Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian
❑ Asian/Pacific Islander ❑ Other _____

Does the student have a regular doctor? ❑ Yes ❑ No
Name: _____
Telephone: _____
Address: _____

Does the student have a regular dentist? ❑Yes ❑ No
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
Relationship:_____ Select Relationship ___
Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Tel: _____Cell: _____
Email: _____

Parent/Legal Guardian
Relationship:_____
Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Tel: _____Cell: _____
Email :_____

If legal guardian, relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑ Other: _____
Tel: _____Cell: _____
Email: _____
Preferred Language of Parent / Guardian:_____
Is the student in Foster Care ❑ Yes ❑ No
Foster Care Agency Name:_____
Case Worker: _____
Phone:_____ Fax:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

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 Montefiore Medical Center's School-Based Health Program. 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. By signing below, I acknowledge that I have been provided a copy of the "Notice of Practices" from Montefiore Medical Center. My signature also gives my consent to contact other providers who have examined my child.

X _____ _____ _____
Signature of Parent/Guardian **Print** **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 **Print** **Date**

Montefiore School Health Program
Insurance Form

Office Use Only

Name of Student:_____ **Medical Record #:** _____

Date of Birth: _____/_____/_____
Mo Day Year

The Montefiore School Based Health Centers provide services to all students who are registered to receive services at **no cost** to the student or his/her family.

- In order to cover our program costs, we bill Medicaid and other insurance carriers to receive payments.
- You may receive a notice called an Explanation of Benefits (EOB) from your insurance carrier with information regarding the services billed and the payments that have been approved.
- You **will not** receive a bill from The Montefiore School Based Health Program to pay for any services provided at The Montefiore School Based Health Centers.

INSURANCE INFORMATION

Does your child have health insurance? Select Answer

If no, what is the best time to contact you?

Does your child have Medicaid? Select Answer

❑ Medicaid ID #

❑ **If your child had Child Health Plus?** Select Managed Care Plan
CHP #

Does your child have VISION insurance? Select One
Complete below or attach a copy of your insurance card.

Vision Insurance Name: _____
Vision Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____
Group #: _____
Name of Insured: _____
Relationship to patient: _____
Insured's Date of Birth: Sex: ☐ F ☐ M

Does your child have OTHER HEALTH Insurance? Select One

Complete below or attach a copy of your insurance card.

Health Insurance Name: _____
Health Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____
Group #: _____
Name of Insured: _____
Relationship to patient: _____
Insured's Date of Birth: Sex: ☐F ☐M

Does your child have DENTAL Insurance? Select One

Complete below or attach a copy of your insurance card.

Dental Insurance Name: _____
Dental Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____
Group #: _____
Name of Insured: _____
Relationship to patient: _____
Insured's Date of Birth: Sex: ☐ F ☐ M

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT
I authorize payment of medical benefits to which the patient named below ("my child") is entitled directly to Montefiore School Based Health Program (MSHP), to cover the cost of the care and treatment rendered to my child at Montefiore School Based Health Centers ("SBHC").

2. RELEASE OF INFORMATION
In the event my Insurer denies payment to MSHP for services rendered to my child, I hereby give my consent to have an authorized representative of the Hospital contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to my child by the SBHC, which may be required in order for my insurer to reevaluate its decision to deny payment for such services. I authorize Montefiore School Based Health Program, my treating provider and their respective designees to use and disclose my child's health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying) to insurers and guarantors if needed for payment of SBHC and professional charges.

3. MEDICAID AND/OR OTHER INSURANCE CARRIER – RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS
I certify that the insurance information given by me regarding my child is correct. I authorize any holder of medical or other information about my child to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which my child has coverage any information needed for this or a related claim. I request that payment of authorized benefits be made on my child's behalf to The Montefiore School Based Health Centers for any service(s) furnished to him/her by SBHC providers.

4. INSURANCE INFORMATION
I understand that The Montefiore School Based Health Centers will use various means to determine if my child has any insurance coverage including the Electronic Medicaid Eligibility Verification System or other holders of information about my child. I understand that these other sources of information will be used to confirm any insurance information I provided on the medical consent/registration form.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ Select Relationship
NAME OF PARENT/GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

Montefiore School Health Program
School Based Health Center Parental Consent Form

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 Montefiore Medical Center 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 **BOX 2**
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

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 Montefiore Medical Center's 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.)
* Vision and hearing screening results
* Immunizations (required/recommended)
* 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 (does NOT include HIV/STI information 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

Montefiore School Health Program
Basic Health History

Childs Name	DOB (Mo/Day/Year)	Grade	School

Dear Parent/Guardian: Your child's health is important to us. Each year we conduct a Brief Health Assessment on every child enrolled in the Montefiore School-Based Health Center to understand his or her health care needs. This includes checking height, weight, and blood pressure. We also review the vaccine record. This does not replace the full physical exam that children should get every year with their usual health care provider. Please include the name of your child's health care provider so we may work together in your child's care.

If your child does not have a health care provider, we can do the full physical exam at the school health center. Insurance is not required. We are part of Montefiore Medical Center, and use the same medical record as the Montefiore Health System. This means we can communicate directly with Montefiore doctors through your child's medical record. We will always inform you if your child is ill and needs to leave school or seek urgent care. Please let us know if your contact information changes. To help the School Health team understand your child's health needs for ongoing care and in case of emergency, please answer the following questions.

Has your child had any serious or chronic health problems?	**No**	**Yes**
Asthma		
Depression or Anxiety *(circle one or both, if yes)*		
Overweight or Obesity		
Other Chronic Conditions (Diabetes, Sickle Cell, etc.)		
Was your child ever diagnosed with a heart murmur?		
Does your child take any medications regularly? **If yes, please list the name, dose and how often it is taken.**		
Has your child ever been hospitalized or had surgery? **If yes, for what?**		
Has your child ever had chicken pox disease? **If Yes, Age_____**		
Allergies to medications or food?	**No**	**Yes**
Is your child allergic to any medications? **If yes, please list**		
Is your child allergic to any foods? **If yes, please list:**		
If yes, does your child have an Epi-pen?		

Have any family members had any of the following problems? Check all that apply.	**Mother**	**Father**	**Sibling**	**Grand parent**	**Other**
Asthma					
Diabetes					
Heart attack or stroke before age 45 years					
High Cholesterol					
Smoking tobacco cigarettes/cigars					
Other:					
Other:					
Deceased					

If your child comes to the School-Based Health Center with minor pain or other minor symptoms, we may give one of the following **medications,** as our provider deems medically appropriate, unless your child has a specific allergy of which we are aware**.**

Acetaminophen (Tylenol) or Ibuprofen (Motrin) for pain-relief such as for headache or menstrual cramps	Select an Answer
Maalox for stomach ache or nausea	Select an Answer
Pepto-bismol for diarrhea or upset stomach	Select an Answer
Loratadine (Claritin) for seasonal allergies	Select an Answer
Pseudoephedrine for cold symptoms	Select an Answer

If you do not want your child to receive any of these medications without speaking to the medical or dental provider first, please check the box below.

If you check this box and we cannot reach you, your child will NOT be given any medication at this visit. ☐

The NYS Department of Health requires us to ask the following questions about risk for tuberculosis and risk for lead poisoning.	**No**	**Yes**
Has your child ever had tuberculosis or a positive skin test for tuberculosis? **If Yes, Age_____Yr. _____**		
Has your child been exposed to anyone with tuberculosis (TB) disease? If Yes, When_____ Who _____		
Does your child have close contact or live with a person who has a positive TB skin test? **If Yes, When? _____**		
Has your child lived in the United States for less than 5 years? **If Yes, where?**		
Has your child traveled outside the US for more than one month? **If Yes, Age _____ Where? _____**		
Has your child traveled to, or used products (glazed pottery, folk remedies, cosmetics, foods, or spices) imported from Haiti, Mexico, Dominican Republic, Pakistan, Bangladesh?		

Date (Mo/Day/Year)	*Name*	*Signature*	Select Relationship *Relationship to child*

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Summary of Your Privacy Rights

THIS SUMMARY DESCRIBES YOUR RIGHTS AND OUR RESPONSIBILITIES WITH RESPECT TO THE PRIVACY OF YOUR MEDICAL INFORMATION. FOR DETAILED INFORMATION, PLEASE ASK US FOR A COPY OF MONTEFIORE'S NOTICE OF PRIVACY PRACTICES.

Your privacy is very important to us, and we are committed to protecting health information that identifies you ("Health Information"). We are required by law to maintain the privacy of Health Information that identifies you. Special privacy protections apply to HIV, alcohol and substance abuse, mental health and genetic information.

How we may use and disclose health information about you

For Treatment

We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. We also may disclose Health Information to people outside of Montefiore who may be involved in your medical care.

For Payment

We may use and disclose Health Information so that we may bill for treatment and services you receive at Montefiore and can collect payment from you, an insurance company or another third party. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes.

Other Uses and Disclosures

We will disclose medical information about you when required to do so by international, federal, state or local law. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the Health Information is necessary for such functions or services. We may disclose Health Information for public health activities. We may disclose Health Information to a health oversight agency for audits, investigations, inspections, and licensure. Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission.

Your Rights Regarding Health Information About You

You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. You may ask us to correct your records f you believe they are incorrect or incomplete. You have the right to request a list of other persons or organizations to whom we have disclosed your Health Information. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You may also have the right to request a limit on the Health Information we disclose about you to your health plan or to someone who is involved in your care or the payment for your care. You have the right to request that we communicate with you about medical matters in a more confidential way or at a certain location. If there is improper access, use or disclosure of your Health Information, we will notify you.

You have the right to a paper copy of our detailed Notice of Privacy Practices. Please ask your provider or go to our web site, http://www.montefiore.org. If you believe your privacy rights have been violated, you may file a complaint with Montefiore or with the Secretary of the Department of Health and Human Services. To file a complaint with Montefiore, contact our Privacy Officer at 718-920-8239 or privacyofficer@montefiore.org.