SUNY DOWNSTATE Medical Center

Department of Family Medicine

Dear Parent/Guardian(s):

Greetings! SUNY Downstate Medical Center offers health services at the School Based Health Center located on the MS 51 Campus in Room 134.

Services include:

- Physical Exams ("check-ups")
- Mental health services
- Urgent care
- Health education and counseling
- First aid
- Immunizations (such as Influenza, Tetanus/Pertussis & Meningococcal)
- Prescriptions
- Asthma and diabetes management
- Age appropriate reproductive health care
- Screening for vision, hearing, dental, and asthma
- Screening and referral for health insurance

Please complete the following documents to ensure that your child will have access to this facility during the school year:

- NYC Department of Education School Health Program consent form
- Over the counter medication consent form
- Health insurance information form (for billing purposes)
- HIPAA privacy form

Return all completed and signed documents to Room 134 as soon as possible.

Thank you! We look forward to working with you and your child!

Regards,

The MS 51 School Based Health Center Team
350 5th Avenue, Room 134
Brooklyn, NY 11215
(718) 330-9363

Revised: 8/2012

NYC Department of Education School Health Program
School Parental Consent Form (Grades PK- 8)

William Alexander Middle School 51
SUNY Downstate Medical Center
350 5th Avenue. Room 134
Brooklyn, NY 11215

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____
Student's First Name: _____
Date of Birth: ____ / ____ / ____
Month Day Year
Sex: O Male O Female Grade _____
Ethnicity: O Hispanic O Black O White O American Indian
O Asian/Pacific Islander O Other _____

Student's Social Security Number: _____ (Voluntary. If disclosed, this information will only be used for Health Insurance purposes).

Student Address: _____
_____ __ __ _____
City State Zip Code

Who is the student's regular doctor?
Name: _____
Telephone: _____ _____
Address: _____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian-If Applicable
Last Name: _____ First Name: _____
Relationship of legal guardian to student
O Grandparent O Aunt or Uncle O Other: _____

Contact Information for Parent or guardian
Home Tel: _____ Work Tel: _____
Beeper/Cell:

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell:

INSURANCE INFORMATION

Does your child have Medicaid?
O No O Yes: Medicaid ID # _____

Does your child have Child Health Plus?
O No O Yes: CHP# _____

Which Plan?
O Affinity O NYP Community Health Plan
O Neighborhood O Amerigroup
O HIP O Health Plus
O Other: _____ _____ _____

Does your child have any other insurance?
O No O Yes: Name: _____
Coverage Number: _____

If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a NY State approved low-income health insurance plan?
No / Yes What is the best time to contact you? _____

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

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 SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL School-Based Health Center.

NOTE: 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 or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. Your decision to grant consent is voluntary and may be revoked at any time. If you revoke consent, your revocation is not retroactive.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* Date

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* Date

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

NYC Department of Education School Health Program
School Parental Consent Form
William Alexander Middle School 51
SUNY Downstate Medical Center at Long Island College Hospital
350 5th Avenue, Room 134
Brooklyn, NY 11215

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL 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. 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.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. Annual health questionnaire/survey.
10. Assessment of medical need for related services (e.g., occupational therapy, physical therapy, speech) recommended on your child's Individualized Education Plan in connection with possible Medicaid claiming for these services.

PARENTAL CONSENT FOR RELEASE OF HEALTH AND STUDENT RECORD INFORMATION

My signature on page 1 of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

My signature also provides consent to the release from the School-Based Health Center to the NYC Department of Education of medical information as outlined below, and from the DOE to the SBHC of medical and student record information as outlined below, in order to meet regulatory requirements or assist in Medicaid and other insurance claiming, if applicable, or in connection with the student's health and participation in school. I understand that this information will be protected in accordance with Federal and State law and Chancellor's Regulations on confidentiality.

Information Required by Law or Chancellor's Regulation:
- New Entrant Exam (Form CH-205)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results

Information for Insurance Claiming Purposes:
- Health insurance coverage
- Individualized Education Program (IEP) information

Information Relating to Health and Student's Participation in School:
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Enrollment in School-Based Health Center

My signature on page 1 of this form also gives my consent to SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL to contact other providers that have examined my child and to obtain insurance information.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical or student record 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.

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)

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

SUNY DOWNSTATE Medical Center

Allergy/Medication Form

Answers to the following questions will help the school-based health center to treat your child more effectively.

Does you child have any medical problems? Yes ___No___ if yes please explain

_____

Does your child have asthma? Yes___No___

Does your child have any known allergies to foods or medications? Yes___No___

If yes please list:

Food or Medication	Symptoms or Reactions to Food/Medication
1._____	_____
2._____	_____

The following over-the-counter medications can be administered on-site in the school-based health center.

Tylenol
Advil/Motrin
Maalox
Pepto-Bismol
Kaolin-Pectin(antidiarreal)
Children's Cold/Cough Syrup (Robitussin)
Benadryl (Antihistamine)
Dimetapp (Antihistamine)
Sudafed (Nasal Congestant)
Anbesol Gel
Bacitracin Ointment
Lotrimin1% Cream (antifungal cream)
Hydrocortisone 1% cream (mild steroid cream)

Please indicate whether the Nurse Practitioner or Physician has your permission to administer over-the-counter medication to your child when appropriate.

Yes____No_____.

I would like to be notified before my child receives any medications Yes____No____

If you would like to be notified before your child receives any medications please note that medication will be withheld until you can be contacted.

Parent/Guardian Name _____ Parent/Guardian Signature _____

PLEASE SEE BACK SIDE OF PAGE FOR INSURANCE INFORMATION

SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn at Long Island College Hospital

HEALTH INSURANCE INFORMATION
PLEASE FILL OUT COMPLETELY

Please check one;

Managed Care-Private Insurance _____
Medicaid Managed Care _____
Medicaid _____
Private Insurance-Non Managed Care _____
No Insurance _____

Insurance Company's name and Complete Mailing Address

Name:_____

Address:_____

_____

City State Telephone number

Address where claims are sent if different from insurance company's address:

_____

Insured's Name: _____

Last Name First Name Middle Initial Date of Birth

Parent(s)/Guardian Name:

_____

Last Name First Name Middle Initial Date of Birth

Insured's I.D.# or Social Security #:_____

Parent(s)/Guardian Social Security #:_____

Parent/Guardian Phone number; Work:_____ Cellphone:_____

Insured's Policy#:_____

Employer's Name:_____

Employer's Address:_____

_____

City:_____ State:_____ Telephone #:_____

Child's Social Security#:_____

If you or your child has Medicaid, please provide the number in the spaces below

_____

(Example: A B 1 2 3 4 5 C)

SUNY DOWNSTATE Medical Center

HIPAA PRIVACY FORM
NOTICE OF PRIVACY ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.

Name of Patient/ Personal Representative: _____

I. Notice of Privacy

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by SUNY Downstate Medical Center Health Science Center at Brooklyn and how you can obtain access to and control this information.
Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.downstate.edu. We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

By signing below, I acknowledge that I received the Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT/ PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

For SUNY Downstate employee (official) use only:
__ Patient would not acknowledge receipt of NOP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:

_____
_____
_____

II. Individuals Involved in Care

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital or about the unfortunate event of your death.

Name: _____
Address: _____
_____
_____
Phone #: _____
Relation: _____

Name: _____
Address: _____
_____
_____
Phone #: _____
Relation: _____