SCHOOL-BASED HEALTH CENTER CONSENT PACKET

Children's Aid
Every step of the way

At our school-based health center, your child can receive the services listed below, **regardless of immigration status.** **We accept all insurances** and provide insurance assistance. Your child can use our services and see his or her other doctors as well.

The way you access health care does not change, it just becomes easier:

- **You continue to maintain your same insurance.**
- **You keep using your private doctor, with whom we will work to ensure your child gets the best care.**
- **You can keep seeing your child's doctor as much as you need, no matter how much you use our center.**

SCHOOL-BASED HEALTH CENTER SERVICES INCLUDE:

- **Complete physical examinations**
- **Immunizations**
- **Acute care**
- **Chronic care (diabetes, asthma, etc.)**
- **Behavioral health counseling and services**
- **Access to care 24 hours/day, 7 days/week**

You can contact our doctors 24/7 whenever your child is ill by calling 212-567-6066.
All information provided is kept confidential.

RETURN FORM TO ROOM 106 or via email at WaHiSBHC@childrensaidnyc.org

Children's Aid
PS 5
School Based Health Center
3703 Tenth Avenue, Room #106
New York, NY 10034
Phone- 212-567-6066

BOX 1 **SCHOOL BASED HEALTH CENTER SERVICES**

I consent for my child to receive health care services provided by the State-licensed health professionals of CHILDREN'S AID 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 students 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. Nutrition and weight counseling
7. 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.
8. 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.
9. Dental examinations including: diagnosis, treatment, and sealants where available.
10. Referrals for service not provided at the school-based health center.
11. Annual health questionnaire/survey.

BOX 2 **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**

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 CHILDREN'S AID 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 the Department of Education's Office of School Health (DOE/OSH)

CHILDREN'S AID-School-Based Health Center

PS 5

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's First Name: _____

Student's Last Name: _____

Student's Date of Birth: ____/____/____
Month Day Year

Student's Address: _____

____ ____ ____ ____
Apt. City State Zip Code

Student's email: _____

Student's cellphone: _____ ❑ Ok to text

*** Student's Social Security Number:** _____

Sex: ❑ Male ❑ Female **Grade:** _____

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

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

PARENT INFORMATION

Parent/ Legal Guardian:
Name (First and Last): _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

Parent/Legal Guardian:
Name (First and Last): _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

If legal guardian, relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: _____
Preferred Language of Parent/Guardian: _____

Additional Emergency Contact:
Name (First and Last): _____
Relationship to Student: _____
Home or Work Tel: _____
Cell: _____

PRIMARY CARE PROVIDERS AND INSURANCE INFORMATION

List the student's regular doctor, if they have one
Name: _____
Telephone: _____
Address: _____
When was your child's last physical exam? ____/____ (month/year)

Indicate the Pharmacy where we can send prescriptions.
Pharmacy _____
Pharmacy Address: _____
Pharmacy Tel: _____

Please provide copy of both sides of your insurance card to the SBHC

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

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

Which health plan provides your Medicaid/CHP Managed Care?
❑ Affinity ❑ Empire BC/BS Health Plus/Amerigroup
❑ Fidelis ❑ Emblem Health(HIP/GHI)
❑ Metro Plus ❑ United Healthcare
❑ WellCare ❑ Healthfirst
❑ MVP ❑ Other: _____

Does your child have other health insurance?
❑ No ❑ Yes, Health Plan: _____
Member ID/Policy Number: _____

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? _____
(Most children in New York State are eligible for public health insurance regardless of their immigration status)

Box 1. 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 CHILDREN'S AID 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**

CHILDREN'S AID - HEALTH AND WELLNESS DIVISION

HEALTH HISTORY FORM

Children's Aid
Every step of the way

Patient's Name: _____ Date Of Birth: _____

Telephone Number: _____ Does your child have a private Dentist who s/he sees? ☐ Yes ☐ No

Does your child have any allergies to medication or food? ☐ Yes ☐ No

Name of Medication(s): _____

Name of Food(s): _____

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

Medication(s): _____ Dosage: _____

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

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

☐ Mumps ☐ Chicken Pox ☐ Meningitis ☐ Measles ☐ Tuberculosis
☐ Rheumatic Fever ☐ Hepatitis ☐ Mononucleosis ☐ Pneumonia ☐ Rubella
☐ Urinary Tract Infections ☐ Other Illnesses: _____

Does your child have any health problems (concerns, past or present). Please check any problems that your child has or has 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 ☐ Intestinal Disease ☐ Menstruation Problems
☐ Kidney Disease ☐ Lead Poisoning ☐ Liver Disease ☐ Shortness of Breath
☐ Overweight/Underweight ☐ Sickle Cell Disease/Trait ☐ Skin Rashes ☐ Others: _____
☐ Stomach Ache ☐ Vision Problem ☐ Thyroid Problems

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 or deceased) have any of the following medical problems?

Problem	Relative (in relation to child)	Deceased
☐ Asthma		Y N
☐ Diabetes		Y N
☐ Heart Disease		Y N
☐ Epilepsy		Y N
☐ Tuberculosis		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: _____

X Signature: _____ Date: _____

(For Office Use Only)
Reviewed by Physician, NPP, RN or PA: _____ **Date:** _____

Children's Aid
Every step of the way

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this form, please ask to speak to our Privacy Officer in person or by phone at our main phone number of 347.778.5396.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the top of this page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

(cont...)

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services

We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Parental Access

State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act according to the laws of New York and will make disclosures following such laws.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

The effective date of this notice is October, 2013.