It's fast and easy for your child to receive health care services through the Morris Heights 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 staffed by licensed professionals from Morris Heights Health Center.

Please know that your child can use the School-Based Health Center and see their other doctors as well. Signing this consent does not change your child's insurance, does not change your child's 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**, regardless of insurance status. However, the SBHC is allowed to bill insurance if your child has health insurance. There are **no co-pays** for SBHC services, and **you will never receive a bill.** If your child has health insurance, please complete the insurance information section on the attached consent form.

School Based Health Center Services include:

- Primary Care Services
  - Physical Exams (including for sports and working papers)
  - Vaccinations
  - Medications and Prescription Management
  - Laboratory Tests
  - Screening for vision, hearing, asthma, and other medical conditions
  - Treatment for acute and chronic conditions
  - For Adolescents: Age-appropriate reproductive health services
- Health Education
- Mental Health Counseling
- Dental Services (where available)
- Telemedicine Virtual Visits (where available)

The School Based Health Center is located in your child's school and is open every school day between the hours of 8:00am to 4:00pm. Access to an on-call provider is also available on weekends and after hours.

To register your child, please **read, complete, and sign** the attached enrollment form. You or your child can return the completed enrollment form to the main office or the School-Based Health Center. If you have any questions, please call us at **(718) 425-3828.**

We invite you to visit us online at www.mhhc.org/our-services/school-based-health-centers/ where you can take a virtual clinic tour, get more helpful information, educational materials and general program updates. We look forward to meeting you and providing health services for your child!

Sincerely,

Lucy Paez Stelzner — Director, School Based Health Program
Sarmistha Mukherjee — Medical Director, School Based Health Program

Morris Heights Health Center
School Based Health Center

Summary of Your Privacy Rights

This summary describes Your Rights and Our Responsibility regarding the privacy of your medical information. A detailed copy of our Notice of Privacy Practices is available upon request.

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

How we may use your disclosed health information:

For treatment

MHHC 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 your care. We may also disclose Health Information to people outside of MHHC who may be involved in your medical care.

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.

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 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. You may ask MHHC to correct your records if 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 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. 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 or breach, 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 a member of our health care staff or visit our website at www.mhhc.org. If you believe your privacy rights have been violated, you may file a complaint with Morris Heights Health Center or with the Secretary of the Department of Health and Human Services. To file a complaint with Morris Heights Health, call our Compliance Hotline at 718-299-2971.

Our Responsibilities

We will follow the duties and Privacy Practices describes in this notice. We will provide you with a copy. We are required by law to maintain the privacy and security of your Protected Health Information (PHI).

Morris Heights Health Center **School Based Health Center Parental Consent Form**

Health Care Service Provider address: _____

Name of School(s): _____

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

STUDENT INFORMATION

Student Last Name: _____

Student First Name: _____

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

Student Address: _____

_____
City State Zip Code

School: _____ **Grade:** _____

Student ID # (OSIS): _____

Student Cell Phone: _____

Student Email: _____

***Student Social Security Number:** _____

Optional field: Used for insurance purposes only

Sex at Birth: ❑ Male ❑ Female **Pronouns:** _____

Gender Identity (*check all that apply*): ❑ Male ❑ Female
❑ Non-Binary ❑ Transgender ❑ Other: _____

Race (*check all that apply*): ❑ Black/African American ❑ White
❑ Asian ❑ Multiracial ❑ Native Hawaiian/Pacific Islander
❑ American Indian/Alaska Native ❑ Other _____

Ethnicity: ❑ Hispanic or Latino/a ❑ Not Hispanic or Latino/a

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: _____

Preferred Language of Parent/Guardian: _____

ADDITIONAL EMERGENCY CONTACT

Name: _____

Relationship to Student: _____

Telephone: _____

HEALTHCARE PROVIDER INFORMATION

Does your child have a regular doctor? ❑ Yes ❑ No

Name: _____

Practice/Clinic Name: _____

Telephone: _____

Address: _____

Does your child have a regular dentist? ❑ Yes ❑ No

Name: _____

Practice/Clinic Name: _____

Telephone: _____

Address: _____

INSURANCE & PHARMACY INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have Child Health Plus?

❑ No ❑ Yes: CHP # _____

Does your child have other health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Name of the Insured: _____

Indicate the Pharmacy where we can send prescriptions.

Pharmacy_____

Pharmacy Address: _____

Pharmacy Tel: _____

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 PRIMARY CARE SERVICES

I have read and understand the services listed in Box 1 on the next page and my signature provides consent for my child to receive services provided by the MORRIS HEIGHTS HEALTH CENTER School-Based Health Center. My signature indicates I have received a copy of the Notice of Privacy Practices and also gives my consent to contact other providers who have examined my child.

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, married, legally emancipated, or runaway or homeless youth.

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 the next page and my signature indicates my consent to release medical information as specified in the Box 2 section only.

X _____ _____

Signature of Parent/Guardian **Date**

Box 3. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER DENTAL SERVICES

I have read and understand the dental services listed in Box 3 attached and my signature provides consent for my child to receive the listed dental services provided by the MORRIS HEIGHTS HEALTH CENTER School-Based Health Center.

X _____ _____

Signature of Parent/Guardian **Date**

Morris Heights Health Center **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 MORRIS HEIGHTS HEALTH 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 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, hearing, asthma, obesity, scoliosis and other medical conditions, first aid, and required and recommended immunizations (additional permission required for 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, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: smoking and drug or alcohol use, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Oral health screening, fluoride treatment, where available.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

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

My signature on the reverse side of this form authorizes release of health 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 health information as specified below to be given to the 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 health 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 MORRIS HEIGHTS HEALTH CENTER School-Based Health Center to release specific health information of the student named on the reverse page to the 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.

I understand that information to be released to the NYC 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 my child, includes but is not limited to:

Comprehensive Physical Exam (Form CH-205 or Equivalent) Immunizations (required/recommended) Vision and hearing screening results	Any Other Information deemed Necessary to Protect a Student's Health or Safety
Diagnosis of Chronic Illness (including *Medication Administration Forms* or *Diabetic Medication Administration Forms*) Conditions which limit a student's daily activity	Information required to complete the DOE Incident Report or Office of School Health Principal Communication Form for OORS Reporting.
Diagnosis of certain Communicable Diseases (**does NOT include HIV/STI information)**	Health Insurance Coverage Enrollment in School-Based Health Center
Individualized Education Program (IEP) documents	Conditions that require transport to an Emergency Department

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*

SCHOOL-BASED HEALTH CENTER DENTAL SERVICES BOX 3

Dental services include: 1) Examination/screening by a dentist or dental hygienist, 2) Teeth cleaning, 3) Dental sealants, 4) Fluoride treatment, 5) Silver Diamine Fluoride (SDF), 6) Dental X-rays, 7) Referrals (if needed). For services other than the preventative dental services listed above, MORRIS HEIGHTS HEALTH CENTER will notify the parent/guardian of the recommended services and treatments for their child **before** they are provided. Based on the child's needs, these may include fillings and the use of anesthetics or medications.

Basic Health History Form

Dear Parent/Guardian: Your child's health is important to us. To help the Health Center better understand their healthcare needs and/or care for them in case of an emergency, please fill out this brief and confidential health history form.

Child's Name:	Date of Birth:	School:	Grade:

Your child's health history	Yes	No	Not Sure
Does your child have any allergies to any medicine? If yes, for what?			
Does your child have any allergies to any food? If yes, for what?			
Do you have any concerns about your child? If yes, for what?			
Does your child take any medications every day? If yes, for what?			
Has your child ever been admitted to the hospital or have any surgeries? If yes, for what?			
Does your child have a regular doctor outside of school? If yes, who? _____ Date of last physical:			
Does your child have a regular dentist outside of school? If yes, who? _____ Date of last exam:			
Is your child exposed to marijuana, cigarettes, e-cigarettes, vaping, or juul?			

Name of Parent/Guardian:	Date
Signature:	
Relationship to child:	

Please call the clinic with any questions.
Thank you!

Who does the child live with most of the time? (Please circle)

Parents Grandparents Mother only Father only Stepparents Sibling Foster parents Others: _____

In the past year, have there been any major changes in your family? (Please circle)

Marriage Separation Divorce Moving Loss of job New School Births Serious Illness Deaths Other: _____

Does your child have or ever had any of the following?	Yes	No	Not Sure
Allergies			
Anxiety/Depression			
Attention Deficit/Hyperactivity Disorder (ADHD)			
Asthma			
Diabetes			
Heart Problems			
Problems in school			
Seizures			
Sickle Cell Disease or Trait			

Have any family members ever had any of the following problems?	Mother	Father	Sibling	Grand-parent	N/A
Asthma					
Blood Disorders/Sickle Cell Disease					
Mental Health Problems					
Diabetes					
Heart attack or Stroke before age 50					
High blood pressure					
High Cholesterol					
Cancer					
Other:					

FOR OFFICE USE ONLY:	
Reviewed by:	Date: