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 consisting of medical and mental health providers from Morris Heights Health Center.

Please know that your child can use the School-Based Health Center and see your other doctors as well. Signing this consent <u>does not</u> change your insurance, <u>does not</u> change your private doctor, and <u>does not</u> 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 **<u>no cost</u>** to you, regardless of insurance status. The SBHC can bill insurance; however, there are **<u>no co-pays for you,</u>** and **<u>you do not receive a bill.</u>**

<u>School Based Health Center Services include:</u>

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions
- Age appropriate reproductive health care
- In-person or Remote Telehealth Visits
- Health Education and Counseling
- Mental Health Counseling Services
- Screening for vision, hearing, asthma, obesity, and other medical conditions
- Access to care 24 hours/day, 7 days/week
- Dental Services-preventative care oral cleanings, sealants, and fluoride varnish applications

To register your child for the services of our School Based Health Center, please read and complete and sign the Registration information on the Parental Consent forms. The complete registration includes completing:

😊 **Parental Consent Form and**
😊 **Medical Summary**

Give the completed forms to your Principal's Office or directly to the School Based Health Center at the school. The completed forms can also be emailed directly to the School Based Program at: sbhcquestions@mhhc.org

The School Based Health Center at your child's school is opened every school day between the hours of 8:00am - 4:00pm.

We look forward to meeting you and to providing health services to your child.

We invite you to visit us online at www.mhhc.org where you can take a virtual clinic tour, get more helpful information, educational materials and general Program updates.

Feel free to give us a call at 718.483.1270 ext. 2907 for more information. We are here for you!

Yours in Health and Wellness,

Kay-Ann Lawrence – Director, SBHC Program
Dr. Sarmistha Mukherjee – Medical Director, SBHC Program

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 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
❑ Healthfirst
❑ Emblem Health(HIP/GHI)
❑ WellCare
❑ Fidelis
❑ Empire BC/BS Health Plus
❑ Metro Plus
❑ 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 ______________________(HCSP) 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**

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 ________________________ ________________________(HCSP) 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 ____(HCSP) 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

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

MORRIS HEIGHTS HEALTH CENTER
SCHOOL-BASED HEALTH CENTER

MEDICAL HEALTH HISTORY FORM

Child's Name: ____
Child's Birthdate: ____
Are there any problems that concern you about your child?
____
____

Does your child have any allergies (food, medication, environmental)? Allergy: Reaction:
____
____
____

Current medications (include vitamins/fluoride/supplements):

1.____ Prescribed by:___________________________________
2.____ Prescribed by:___________________________________
3.____ Prescribed by:___________________________________

Please provide the Name, Address and Contact of Primary Care Provider (PCP):
Name of PCP:____
Address: ____
Phone #: __________________________ **Email:** ______________________________ **Fax#:**____________________

Date of last physical examination: ________________________ **By whom:** ______________________________
Date of last dental examination: __________________________ **By whom:** ______________________________

List hospitalizations, illnesses, accidents, broken bones, surgeries, etc.
Please Explain:
____
____

Indicate which of the following conditions or problems your child has ever had or that concerns you:
Date/Explain Date/Explain
Skin trouble __________________ Rheumatic Fever ____________________
Eye problems __________________ Chicken Pox ____________________ Frequent ear infections __________________
Joint aches or pain ____________________
Difficulty hearing __________________ Loss of consciousness ____________________
Frequent nose bleeds __________________
Frequent sore throats __________________
Pneumonia __________________________
Other lung problems __________________
Heart murmur _______________________
Jaundice ____________________________
Frequent stomach aches ____________________
Frequent diarrhea _________________________
Speech problems __________________________
Constipation ______________________________
Black stool _______________________________
Kidney or bladder infection __________________
Painful urination __________________________
Bedwetting ________________________________
Painful periods ____________________________

MORRIS HEIGHTS HEALTH CENTER
SCHOOL-BASED HEALTH CENTER
MEDICAL HEALTH HISTORY FORM

Anemia ___________________

Does your child see a specialist (ex. Physical or Occupational Therapist, Speech or Counselor)?
Yes ____ No_____
Explain: ____

Who else lives at your child's home?____

Mother _______________________ (AGE)_________________________ (Healthy) YES______________ NO _____________

Father _______________________ (AGE)_________________________ (Healthy) YES______________ NO _____________

Siblings _______________________ (AGE)_________________________ (Healthy) YES______________ NO _____________

_______________________ (AGE)_________________________ (Healthy) YES______________ NO _____________

Others _______________________ AGE)_________________________ (Healthy) YES______________ NO _____________

Family History – Check any of the following diseases which relatives (including aunts, uncles, cousins, grandparents) have:

Condition Relationship Condition Relationship
Eczema ______________________ Anemia or blood problems ________________
Seizure disorder _______________ Alcoholism ______________________
Tuberculosis __________________ Kidney disease ______________________
Hay fever ____________________ Cystic Fibrosis ______________________
Asthma ______________________ Cancer ______________________
High blood pressure ____________ Mental retardation ______________________
Heart attack, stroke _____________ Birth defects ______________________
(under 55 years of age) Psychiatric problems ______________________
Diabetes ______________________ Death before 50 years___________
Obesity ______________________
High cholesterol or Other conditions not listed above ______________________
Triglycerides _____________________ ____

OTHER: Do you have any concerns (behavioral, emotional, or otherwise) about this child? If yes, please explain.
____
____

SBHC USE ONLY:

Reviewed by: ________________ Date: _______________

Reviewed by: ________________ Date: _______________