HEALTH CARE AND MORE

FOR YOU AND YOUR FAMILY

THE INSTITUTE FOR FAMILY HEALTH

SCHOOL BASED HEALTH CENTER

- Physical exams
- Care for chronic conditions
- Medications and prescriptions
- Help with insurance enrollment
- Sports clearance
- Pre-employment
- Immunizations
- Hearing and vision screenings
- Reproductive health care
- Mental health services
- Referrals to other providers
- Dental services

We're here every day school is open, from 8:30am–4:00pm. Enroll your child in quality, no-cost, confidential school-based health services today.

NO ONE IS TURNED AWAY.

HARLEM CHILDREN'S ZONE PROMISE ACADEMY I SCHOOL-BASED HEALTH CENTER

245 West 129th Street, 1st fl oor
New York, NY 10027
(347) 773-3203
Fax: (646) 559-4260

For health care for children and adults, visit a health center below or go to institute.org/locations for more locations.

THE INSTITUTE FOR FAMILY HEALTH AT 17TH STREET

230 West 17th Street
(between 7th & 8th Avenues)
New York, NY 10011
(212) 206-5200

HARLEM FAMILY HEALTH CENTER

1824 Madison Avenue
New York, NY 10035
(844) 434-2778

STEVENSON FAMILY HEALTH CENTER

731 White Plains Road
Bronx, NY 10473
(718) 589-8775

It's fast and easy for your child to receive health care services through the The Institute for Family Health's 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 The Institute for Family Health.

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, 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 room 113 of your child's school and is open every school day between the hours of 8:30 am – 4:00 pm. 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 School-Based Health Center in room 113. If you have any questions, please call us at **347-773-3203**.

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

Sincerely,

Elizabeth Ring, CPNP
Medical Director
School-Based Health Centers
The Institute for Family Health

LaKiesha George/Elementary School Principal
Madelaine Shultz/Middle School Principal
Amy Deal/High School Principal
Harlem Children's Zone's Promise Academy I

The Institute for Family Health's School Based Health Center Parental Consent Form

Health Care Service Provider address: 245 West 129th Street, Room 113, NY, NY 10027
Name of School(s): Harlem Children's Zone Promise Academy I

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: q Male q Female **Pronouns:** _____
Gender Identity (*check all that apply*): q Male q Female
q Non-Binary q Transgender q Other: _____
Race (*check all that apply*): q Black/African American q White
q Asian q Multiracial q Native Hawaiian/Pacific Islander
q American Indian/Alaska Native q Other _____
Ethnicity: q Hispanic or Latino/a q 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:
q Grandparent q Aunt/Uncle q Foster Parent q Other: _____

Preferred Language of Parent/Guardian: _____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Telephone: _____

HEALTHCARE PROVIDER INFORMATION

Does your child have a regular doctor? q Yes q No
Name: _____
Practice/Clinic Name: _____
Telephone: _____
Address: _____

Does your child have a regular dentist? q Yes q No
Name: _____
Practice/Clinic Name: _____
Telephone: _____
Address: _____

INSURANCE & PHARMACY INFORMATION

Does your child have Medicaid?
q No q Yes: Medicaid ID # _____
Does your child have Child Health Plus?
q No q Yes: CHP # _____
Does your child have other health insurance?
q No q 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? q No q 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 THE INSTITUTE FOR FAMILY HEALTH'S 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 THE INSTITUTE FOR FAMILY HEALTH'S School-Based Health Center.

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

The Institute for Family Health's 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 THE INSTITUTE FOR FAMILY HEALTH'S 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 THE INSTITUTE FOR FAMILY HEALTH'S 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)**	Conditions that require transport to an Emergency Department
Individualized Education Program (IEP) documents	Health Insurance Coverage Enrollment in School-Based Health Center

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

The Institute for Family Health's School Based Health Center Parental Consent Form

SCHOOL-BASED HEALTH CENTER DENTAL SERVICES **BOX 3**

I consent for my child to receive dental treatment provided by the licensed professionals of The Institute for Family Health (HCSP) as part of the school-based dental program approved by the New York State Department of Health. School-Based Health Center preventative dental services may include:

1. Examination/screening by a dentist or dental hygienist
2. Teeth cleaning
3. Dental sealants
4. Fluoride treatment
5. Silver Diamine Fluoride (SDF), where available***: SDF may be applied on back teeth to halt the progression of cavities. It may discolor any cavities resulting in a brown or black color.***
6. Dental X-rays, where available (if needed)
7. Referrals (if needed)

For services other than the preventative dental services listed above, the HCSP 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, extractions, and the use of anesthetics or other medications.

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 Institute for Family Health's School Based Health Centers for any service(s) furnished to them by SBHC providers.

The Institute for Family Health

BASIC HEALTH HISTORY

School-Based Health Program

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

Child's Name	Date of Birth (mm/dd/yyyy)	School	Grade

Your child's health history	Yes	No	Not Sure
Does your child have any allergies to medications? If yes, what are they:			
Does your child have any food allergies? If yes, what are they:			
Have there been any changes in your child's health in the past year? If yes, what are they:			
Does your child take any medications regularly? If yes, what are they:			
Has your child ever had chicken pox before? If yes, at age:			
Has your child ever been hospitalized or had surgery? If yes, for what?			
Does your child have a doctor you go to and like outside of school? When was their last complete health exam/physical? Date:			
Does your child have a dentist you go to and like outside of school? When was their last dental visit? Date:			

Does your child have any health conditions or issues:	Yes	No	Not Sure
Allergies (seasonal/environmental)			
Anxiety/depression (circle one or both if yes)			
Asthma			
Attention Defecit Disorder			
Diabetes			
Obesity			
Other:			

If your child comes to the Health Center for a small pain (headache/toothache/menstrual cramps) would you like to be called BEFORE your child is given an over-the-counter pain-reliever (like Tylenol/Motrin unless they are allergic)?

Circle one: Yes No

Name	Date (mm/dd/yyyy)
Signature	
Relationship to child	

The NYS Dept of Health requires these questions about risk for tuberculosis and lead intoxication:	Yes	No	Not Sure
Has your child ever had tuberculosis or a positive skin test for tuberculosis? If yes, at age:			
Has your child been around anyone with tuberculosis (TB) disease? If yes, when? Who?			
Does your child have a close contact or live with a person who has a positive TB skin test? If yes, when? Who?			
Has your child lived in the US for less than 5 years? If yes, where else have they lived:			
Has your child travel outside the US for more than one month at a time? If yes, where?			
Has your child traveled to, or used products (like glazed pottery, folk remedies, cosmetics, food, spices) imported from Haiti, Mexico, Pakistan, the Dominican Republic, or Bangladesh?			

Who does the child live with most of the time?

In the past year, have there been any major changes in your family?
Eg: Marriage, Divorce, Deaths, New School, Serious Illness, Births, etc.

Have any other family members, living or dead, had any of the following problems? Check all that apply.	NA	Mother	Father	Sibling	Grand-parent
Asthma					
Blood disorders/sickle cell anemia					
Mental health issue (depression/anxiety)					
Diabetes					
Heart attack or stroke before age 50					
High blood pressure					
High cholesterol					
Obesity					
Smoking tobacco cigarettes/cigars					
Other:					

Please call the health center with any questions. *Thank you!*

THE INSTITUTE FOR FAMILY HEALTH

SCHOOL-BASED HEALTH CENTER