# 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
- Mental health services
- Referrals to other providers

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

**NO ONE IS TURNED AWAY.**

## PROMISE ACADEMY II ELEMENTARY SCHOOL SCHOOL-BASED HEALTH CENTER

1681 Madison Ave, New York, NY 10029
Phone: (646) 448-8211
Fax: (917) 261-7739

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

### STEVENSON FAMILY HEALTH CENTER

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

### WALTON FAMILY HEALTH CENTER

1894 Walton Avenue
Bronx, NY 10453
(718) 583-3060

### HARLEM FAMILY HEALTH CENTER

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

**Institute for Family Health**
**School-Based Health Program**
www.institute.org

Dear Parent/Guardian:

We are excited to announce that your child's school, in partnership with the Institute for Family Health, has opened a full-service health center located inside the school! This is different from your existing school nurse's office.

The School-Based Health Center does everything a school nurse would do, like caring for students who are sick or hurt at school and need first aid or emergency care, but it can also provide some of the same services as a doctor's office or health center outside of school. These services include physical exams for school, sports, or working papers, shots and immunizations, care for diabetes, asthma and other chronic conditions, medications, testing, referrals, mental health counseling, health education, insurance enrollment and more!

Because the Health Center can do more for your child than a school nurse, for your child to be seen at the Health Center for any or all of our services they might need, they need to sign up by returning a Parent/Guardian consent form.

**To enroll your child in the Health Center, please fill out the attached forms:**

- ☐ **Parent/Guardian Consent Form.**
- ☐ **Medical History Form.**
- ☐ A copy of your child's insurance information.

**Frequently Asked Questions:**

**What are the Health Center's hours?**
We are open on school days Monday – Friday 8:30 AM to 4:00PM.

**Does my child need to change their regular doctor or medical provider outside of school?**
No – you can keep your regular doctor, and if your child does need any health care in school, the Health Center can work with you and your doctor to make a plan.

**Do I need to pay for my child's care at school?**
No - we bill health insurance whenever we can to help cover our program costs, but we do not charge co-pays and you will never have to pay for anything your insurance doesn't cover.

**Does my child need to have health insurance?**
We will see your child whether or not they have health insurance. We can also help your child and your family to sign up for or renew your health insurance.

**Does my child need to be a US citizen?**
No, your child does not need to be a US citizen, we do not collect information on citizenship status, or share any of your information outside of the Health Center.

Please call us at any time with questions or concerns, or if you would like to schedule a time to come tour the health center and meet our staff!

Sincerely,
*The School-Based Health Center Team*

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

Health Care Service Provider address: 1681 Madison Ave, New York, NY 10029

Name of School(s): Harlem Children's Zone, Promise Academy II Elementary

***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*

**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

**Please sign Box 1 & 2**

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 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 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**

# 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 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 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)<br>Immunizations (required/recommended)<br>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***)<br>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<br>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***

**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 SPONSOR 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? Circle all that apply:**

Both Parents Mother Only Father Only Stepmother Stepfather Siblings Other Children Foster Parent Other Guardian

**In the past year, have there been any major changes in your family? Circle all that apply**

Marriage Separation Divorce Loss of Job Move to a new Neighborhood New School Births Serious Illness Deaths

Other: _____

| Have any 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