School Name: P.S./M.S. 95
Health Center Telephone: 718-796-3440
Fax: 718-601-2357

Montefiore

Montefiore School Health Program

http://www.montefiore.org/school-health-program

Dear Parent/Guardian:

Your child's school, in partnership with the Montefiore School Health Program, has a comprehensive health center that is different from the school nurse's office. The health center provides students with emergency care and first aid for minor injuries; physical exams for school, sports or working papers, confidential counseling & stress reduction, immunizations, asthma care, nutritional counseling, preventative dental services and more.

To enroll your child in the clinic, please complete the enclosed forms and provide the following:

- Parental/Guardian Consent Form
- Basic Health History Form. All information is kept confidential.
- **Include a copy of your child's immunization record**
- **Include a copy of insurance information.**

Health Center' s FAQs

What are our hours?
We are open school days: Monday – Friday 8:00 AM to 3:30 PM. Closed daily for a half-hour lunch from 12:30pm to 1pm

Who is on the staff?
Medical Provider(s), Mental Health Provider(s), Licensed Practical Nurse, Community Health Organizer and a Senior Clerk. Preventative and restorative dental services are currently available at certain High School Campus locations; preventative dental services are currently available at certain Elementary School Campus location.

Does my child need to be insured?
No, we will see your child regardless of their insurance coverage. We bill insurance whenever possible to help cover our program costs but do not charge co-pays. Insurance is also important to facilitate any referrals to sub-specialists and for diagnostic testing.

Am I responsible for co-pays?
No, we bill insurance whenever possible to help cover our program costs but do not charge co-pays. Insurance is also important to facilitate any referrals to sub-specialists and for diagnostic testing.

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.

Does my child need to change their regular health care provider?
No, you may keep your regular doctor. We work with and communicate with your child's health care providers, specialists or mental health providers whether they are Montefiore or non-Montefiore providers.

We are committed to the health of the students and invite you to share your questions or concerns with us.

Sincerely,

The Montefiore School Health Program

Montefiore

School Name: P.S./M.S. 95
Health Center Telephone: 718-796-3440
Fax: 718-601-2357

Montefiore School Health Program
School Parental Consent Form

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of Montefiore Medical 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 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) among other methods], testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. *FOR ADOLESCENT STUDENTS*: 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.
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
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. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information 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 Montefiore Medical Center 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:
- New Entrant Exam (Form 211S)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results
- Health insurance coverage

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).

My signature on page 1 of this form also gives my consent to Montefiore Medical Center to contact other providers that have examined my child and to obtain insurance information.

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

School Name: P.S./M.S. 75
Health Center Telephone: 718-796-3440
Fax: 718-601-2357

Montefiore School Health Program
Parental/Guardian Consent Form

OSIS #: _____ Office Use Only
Medical Record No. _____

STUDENT INFORMATION

Student's Last Name: _____
Student's First Name: _____
Student's Middle Initial: _____
Date of Birth: _____/_____/_____ (Month / Day / Year)
Student's Social Security Number: _____
Student's School: _____

Sex: ❑ Male ❑ Female Grade _____
Ethnicity: ❑ Hispanic/Latino ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

Preferred Language: _____

Student Address: _____

Apt:#_____ _____ (City) _____ (State) _____ (Zip Code)

Who is the student's regular doctor?
Name: _____
Tel: _____
Address: _____

PARENT/GUARDIAN INFORMATION

Mother's Name
Last: _____ First : _____ DOB: _____

Father's Name
Last : _____ First: _____ DOB: _____

Name of Legal Guardian, If Applicable
Last : _____ First: _____ DOB: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian
Home Tel: _____ Work Tel: _____
Cell: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Cell: _____
Is this student in Foster Care: ❑ Yes ❑ No
Foster Care Agency Name: _____
Address of Agency: _____
Social Worker Name: _____
Phone number: _____

INSURANCE INFORMATION

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

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

Which Plan?
❑ Affinity ❑ UHC Community Plan ❑ Health Plus/ Amerigroup
❑ Fidelis ❑ HIP ❑ Wellcare
❑ HealthFirst ❑ MetroPlus ❑ Emblem Health / GHI
❑ Other: _____

Please indicate the pharmacy that is convenient for you, in order to electronically forward any needed prescriptions to the pharmacy.
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Tel. _____

If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a NY State approved low-income health insurance plan? ❑ Yes ❑ No

Does your child have other Health Insurance? ❑ No ❑Yes, complete below *or* attach a copy of your insurance card:
Health Insurance Name: _____
Health Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____
Name of Insured: _____
Relationship to patient: _____
Insured's Date of Birth: _____/_____/_____ (Mo / Day / Year) Sex: F_____M_____

Does your child have Dental Insurance? ❑ No ❑Yes, complete below *or* attach a copy of your insurance card.
Dental Insurance Name: _____
Dental Insurance Address: _____
City: _____ State: _____ Zip code: _____
Policy #: _____ Group #: _____
Name of Insured: _____
Relationship to patient: _____
Insured's Date of Birth: _____/_____/_____ (Mo / Day / Year) Sex: F_____M_____

BOX 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign box 1 and 2 to complete enrollment

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 Montefiore Medical Center School-Based Health Center. **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 or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____ _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) **Print** **Date**

BOX 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____ _____
Signature of Parent/Guardian **PRINT PARENT/GUARDIAN NAME** **Date**
(or student if 18 years or older or otherwise permitted by law)

Montefiore School Health Program
Basic Health History

School Name: P.S./M.S. 95
Health Center Telephone: 718-796-3440
Fax: 718-601-2357

CHILD'S NAME _____ DOB (mm/dd/yyyy) _____ GRADE _____ SCHOOL _____

Dear Parent/Guardian: Your child's health is important to us. To better understand your child's healthcare needs, the Montefiore School Health Program endeavors to conduct an annual *brief* health assessment on every child in the school. This includes measurement of height, weight and blood pressure, review of a child's immunization record and documentation of a child's medical home. This assessment does not replace the annual *comprehensive* Health Assessment done by your child's Primary Care Provider. You may also request a *comprehensive* Health Assessment at the school-based health center. The Montefiore School Health Program utilizes the same electronic health record used at Montefiore Medical Center, allowing us to communicate with any Montefiore provider. To help the School Health Team be informed of your child's health needs for ongoing care and in case of emergency, please answer the following questions.

Allergies:	**No**	**Yes**
Is your child allergic to any medications? **If yes, please specify:**		
Is your child allergic to any foods? **If yes, please specify:**		
If yes, does the child have an Epi-pen?		
Has your child had any serious or chronic health problems?	**No**	**Yes**
Asthma		
Attention Deficit Disorder		
Depression or Anxiety *(circle one or both, if yes)*		
History of a Heart Murmur		
Other:		
Does your child take any medications regularly? **If yes, please specify name(s) and regimen(s)**		
Has your child ever been hospitalized or had surgery? **If yes, for what?**		
Has your child ever had chicken pox disease? **If Yes, Age_____ Yrs.____**		

Have any of family members, living or deceased had any of the following problems? Check all that applies	**Mother**	**Father**	**Sibling**	**Grand parent**
Asthma				
Diabetes Melliitus				
Heart attack or stroke before age 45 years				
High Cholesterol				
Smoking tobacco cigarettes/cigars				
Other:				

With whom does the child live most of the time? Circle all that apply:				
Both parents	Mother only	Father Only	Stepmother	Stepfather
Grandparent/ Other Adult Relative:	Sisters and Brothers: Ages_____	Other children: Ages_____	Foster Parent	Other Guardian
In the past year, have there been any 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

The NYS Department of Health requires us to ask the following questions about risk for tuberculosis and risk for lead intoxication.	**No**	**Yes**
Has your child ever had tuberculosis or a positive skin test for tuberculosis? **If Yes, Age_____Yrs.**		
Has your child been exposed to anyone with tuberculosis (TB) disease? **If Yes, When?_____ Who? _____**		
Does your child have close contact or live with a person who has a positive TB skin test? **If Yes, When? _____Who? _____**		
Has your child lived in the United States for less than 5 years? **If Yes: Where? _____**		
Has your child traveled outside the US for more than one month? If Yes, Age_____Where?_____		
Has your child traveled to, or used products (glazed pottery, folk remedies, cosmetics, foods or spices) imported from Haiti, Mexico, Pakistan, the Dominican Republic, or Bangladesh?		

We will always inform you if your child is very ill and needs to leave school or seek urgent care. *Please always inform us if your contact information ever changes.*

If your child comes to the school-based health center with minor pain or other minor symptoms, we will give one of the following **over-the-counter medications,** *unless your child has a specific allergy.*

We will make our best effort to inform you, either by calling you or by sending home a letter to you with your child.

Acetaminophen (Tylenol) or Ibuprofen (Motrin) for pain-relief such as for headache or menstrual
Maalox for stomach ache or nausea
Pepto-bismol for diarrhea or upset stomach
Loratadine (Claritin) for seasonal allergies
Pseudoephedrine for cold symptoms

If you do not want your child to receive any over-the-counter medications without speaking to the medical provider first, please check the box below. If you check this box and we cannot reach you by telephone, then the child will not receive treatment and will be sent back to class. ☐

_____ _____ _____ _____

Today's Date (mm/dd/yy) *Name* *Signature* *Relationship to child*

(Check if child is in foster care ☐)