It's fast and easy for your child to receive health care services through the Community Healthcare Network 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 Community Healthcare Network.

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

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

- 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)

Scan here to complete this form online instead.

The School Based Health Center is located in room 507 of your child's school and is open every school day between the hours of 8:00 am – 4:00 pm. Access to an on-call provider is also available on weekends and after hours.

To register your child, please **<u>read, complete, and sign</u>** the attached enrollment form. You or your child can return the completed enrollment form to the School-Based Health Center in room 507. If you have any questions, please call us at **917-521-3130**.

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

Sincerely,

Robert Hayes
President/CEO
Community Healthcare Network

<u>Community Health Academy of the Heights</u>
David Falciani, Principal

Amir Tusher- Assistant Principal- Operations

Natalie Martinez- Assistant Principal- Culture & Climate

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Community Healthcare Network School Based Health Center Parental Consent

Health Care Service Provider address: 504 West 158th Street Room 507 New York NY 10032
Name of School(s): Community Health Academy of the Heights

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: ❑ 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 — 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 Community Healthcare Network (HCSP) 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**

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Community Healthcare Network School Based Health Center Parental Consent

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 Community Healthcare Network (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 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 Community Healthcare Network (HCSP) 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

Your Childs Health

This form asks about your child's health. It will help us give your child the best care possible. Please fill out this form and take it to the School Based Health Center in Room 507.

Your Name: _____ Todays Date: _____/_____/_____
Month Day Year

Your Relationship: _____

Child's Information

Childs Name: _____ **School**: _____

Birthday: _____/_____/_____ **Age**:_____ **Grade**:_____
Month Day Year

In the past year, did your child see a:

Doctor? ❑

Dentist? ❑

Does your child currently take any medicine, supplements, or herbs? Write down any medicines your child takes. Write down medicines that you got from your child's doctor and medicines you buy at the drug store.

Medicine	Reason Taken

Your Child's Health Problems
Check any health problem your child has:

❑ ADHD (Deficit Hyperactive Disorder

❑ Asthma

❑ Chicken Pox

❑ Depression or other mental health problems

❑ Diabetes

❑ Heart Problems

❑ High Levels of lead

❑ Learning Disability

❑ Positive PPD, Tuberculosis, BCG Vaccine

❑ Rheumatic fever

❑ Seizures or Epilepsy

❑ Other Problems: _____

_____

Community Healthcare Network

Family Health Problems

Some health problems run in families. Check any problems that a person in your family, like a mother, father, sibling, grandparent, aunt or uncle has or had. Also write down that person's relationship to your child.

Health Problem	Relationship to Child
❑ A blood illness or stroke	_____
❑ Cancer: Type_____	_____
❑ Depression or other mental health problems	_____
❑ Diabetes	_____
❑ Early Death (before age 45)	_____
❑ High Blood Pressure, heart attack, or other heart problem _____	_____ _
❑ Other Problem: _____	

Who lives with your child? You can check more than one.

- ❑ Mom
- ❑ Dad
- ❑ Stepmom
- ❑ Stepdad
- ❑ Other Adult: _____
- ❑ Legal Guardian
- ❑ Sister
- ❑ Brother

In the past year, have there been any of these changes **in your** family? Check the box if anyone in your child's family:

- ❑ Lost a job
- ❑ Got Married
- ❑ Got Separated
- ❑ Got Divorced
- ❑ Other life change: _____
- ❑ Had a baby
- ❑ Got really sick
- ❑ Died
- ❑ Went to a new school

Do you have any concerns about your child's health or lifestyle?

_____

_____

Is there anything else you want to tell us about your child?

_____

_____

For Clinic Use **ONLY**

Questionnaire received by: _____ on _____
Provider Signature *Date*

Appointment needed/given (note date): _____

Community Healthcare Network