



**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.

**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)

Scan here to complete  
this form online instead.



**The School Based Health Center is located in room 240 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 **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 240. If you have any questions, please call us at **(212) 634-7543**.

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

Sincerely,

**Robert Hayes**  
President/CEO  
Community Healthcare Network

**Seward Park Campus**

**Wallace Simpson**, Essex Street Academy  
**Lowy Joel**, Lower Manhattan Academy Arts Academy  
**Jacqueline D'agostino**, Urban Assembly Academy of Government and Law  
**Scott Conti**, New Design High School  
**John Meesun**, High School for Dual Language and Asian Studies



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# Community Healthcare Network School Based Health Center Parental Consent

**Health Care Service Provider address:** 350 Grand Street Room 240 New York NY 10002

**Name of School(s):** Essex Street Academy; High School for Dual Language and Asian Studies; Lower Manhattan Arts Academy; New Design High School; Urban Assembly Academy of Government and Law

**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	PARENT INFORMATION
<b>Student Last Name:</b> _____ <b>Student First Name:</b> _____ <b>Date of Birth:</b> _____ / _____ / _____ <div style="text-align: center; font-size: small;">Month Day Year</div> <b>Student Address:</b> _____ <div style="text-align: center; font-size: small;">City State Zip Code</div> <b>School:</b> _____ <b>Grade:</b> _____ <b>Student ID # (OSIS):</b> _____ <b>Student Cell Phone:</b> _____ <b>Student Email:</b> _____ <b>*Student Social Security Number:</b> _____ <div style="font-size: x-small;">*Optional field: Used for insurance purposes only</div> <b>Sex at Birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Pronouns:</b> _____ <b>Gender Identity (check all that apply):</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender <input type="checkbox"/> Other: _____ <b>Race (check all that apply):</b> <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other _____ <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Not Hispanic or Latino/a	<b>Parent/Legal Guardian:</b> Last Name: _____ First Name: _____ Home/Work Tel: _____ Cell Phone: _____ Email: _____ <b>Parent/Legal Guardian:</b> Last Name: _____ First Name: _____ Home/ Work Tel: _____ Cell Phone: _____ Email: _____ <b>If legal guardian, relationship to the student:</b> <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____ <b>Preferred Language of Parent/Guardian:</b> _____ <div style="background-color: #d3d3d3; text-align: center; padding: 2px;"><b>ADDITIONAL EMERGENCY CONTACT</b></div> Name: _____ Relationship to Student: _____ Telephone: _____
HEALTHCARE PROVIDER INFORMATION	
<b>Does your child have a regular doctor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Practice/Clinic Name: _____ Telephone: _____ Address: _____	<b>Does your child have a regular dentist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Practice/Clinic Name: _____ Telephone: _____ Address: _____
INSURANCE & PHARMACY INFORMATION	
<b>Does your child have Medicaid?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: Medicaid ID # _____ <b>Does your child have Child Health Plus?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: CHP # _____ <b>Does your child have other health insurance?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Health Plan: _____ Member ID/Policy Number: _____ Name of the Insured: _____	<b>Indicate the Pharmacy where we can send prescriptions.</b> Pharmacy _____ Pharmacy Address: _____ Pharmacy Tel: _____ <b>If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes What is the best time to contact you? _____
Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER PRIMARY CARE SERVICES <span style="float: right;">Please sign Box 1 &amp; 2</span>	
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. <i>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.</i>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>X</b> _____            Signature of Parent/Guardian         </div> <div style="width: 35%;">           _____            Date         </div> </div>	
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.	
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>X</b> _____            Signature of Parent/Guardian         </div> <div style="width: 35%;">           _____            Date         </div> </div>	

# 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

## BOX 2

### HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

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 <i>Medication Administration Forms</i> or <i>Diabetic Medication Administration Forms</i> ) 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 ( <b>does NOT include HIV/STI information</b> )	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 Child's 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 240.

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Your Relationship: \_\_\_\_\_

## Child's Information

Child's 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

☐ Other Problems: \_\_\_\_\_

☐ High Levels of lead

☐ Learning Disability

☐ Positive PPD, Tuberculosis, BCG Vaccine

☐ Rheumatic fever

☐ Seizures or Epilepsy

## 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

☐ Legal Guardian

☐ Dad

☐ Sister

☐ Stepmom

☐ Brother

☐ Stepdad

☐ Other Adult: \_\_\_\_\_

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

☐ Had a baby

☐ Got Married

☐ Got really sick

☐ Got Separated

☐ Died

☐ Got Divorced

☐ Went to a new school

☐ Other life change: \_\_\_\_\_

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): \_\_\_\_\_