Community Healthcare Network
School-Based Health Center, Room 240
Seward Park Campus

Dear Parent:

Community Healthcare Network School-Based Health Center (SBHC) provides health services at the Seward Park Campus. The health services listed below are provided at **no cost to you**, even if your child does not have insurance. The SBHC is allowed to bill the insurance. However, parents/guardians will **not be charged** for any services.
At the SBHC, your child can get:

• School physicals (check-ups)	• Sports physicals
• Medicine and lab tests	• Age-appropriate reproductive health services
• Vaccines (shots)	• Mental health services
• Treatment of health problems	• Nutrition services
• Treatment for emergencies/injuries	• After hours phone service 7 days a week

The Community Healthcare Network SBHC at Seward Park Campus does not replace your child's doctor or change your insurance. Your child can still see their doctor while also getting care at our school-based health center.
If you want your child to get services at Community Healthcare Network SBHC at Seward Park Campus:

1. Please read and fill out the Parental Consent Form.
2. Please have your child take the signed form to their school's principal's office. Or they can bring it to the Health Center in Room 240.

We look forward to meeting you and offering health services for your child by our licensed professionals! To learn more, please visit us or call 212-634-7550 from 8:00a.m - 4:00p.m.

Sincerely,
Seward Park Campus School-Based Health Center

Angelina Almonte, SBHC Program Manager
Stacey Cacciola, MD Director of Pediatrics
Ellen Hollander-Sande, DNP, FNP-C, CLC Family Nurse Practitioner
Shelly Co, DO Mental Health Psychiatric
Hina Afridi, LMSW Mental Health Therapist

Robert Hayes
President/CEO
Community Healthcare Network

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Community Healthcare Network School Based Health Center Parental Consent Form

Health Care Service Provider address: *60 Madison Avenue, New York, NY 10010*
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

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Student Address:_____
_____
City State Zip Code
Student email:_____

***Student Social Security Number:** _____
Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____
List the student's regular doctor, if they have one?
Name: _____
Telephone: _____
Address: _____

Indicate the Pharmacy where we can send prescriptions.
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____
***Indicates optional field: Used for insurance purposes only**

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: _____
Home /Work Tel: _____
Cell: _____
Email: _____
Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

INSURANCE INFORMATION

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

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

Which Plan?
❑ Affinity ❑ Fidelis
❑ Healthfirst ❑ Empire BC/BS Health Plus
❑ Emblem Health(HIP/GHI) ❑ Metro Plus
❑ WellCare ❑ United Healthcare

Does your child have other health insurance
❑ No ❑ Yes, Health Plan: _____
Member ID/Policy Number: _____
Health Insurance Phone: _____

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 SERVICES. Please sign Box 1 & 2

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 COMMUNITY HEALTHCARE NETWORK School-Based Health Center. 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 or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

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 _____ _____

Community Healthcare Network School Based Health Center Parental Consent Form

Signature of Parent/Guardian **Date**

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 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), LARC, other FDA approved methods] testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
7. 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 and medically indicated.
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 BOX 2

My signature on the reverse side of this form authorizes release of medical 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 medical information as specified below 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 COMMUNITY HEALTHCARE NETWORK 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 including but not limited to:

* Comprehensive Physical Exam (Form CH-205 or Equivalent such as sports exams, etc.)
* Vision and hearing screening results
* Immunizations (required/recommended)
* Tuberculin Test results

Information to Protect Health and Safety:

* Conditions which may require emergency medical treatment including chronic illness
* Conditions which limit a student's daily activity
* Diagnosis of certain communicable diseases (does NOT include HIV/STI information and other confidential services protected by law).
* Health insurance coverage
* Enrollment in School-Based Health Center
* Individualized Education Program (IEP)

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 240.

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): _____

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