SUNY DOWNSTATE
Health Sciences University
University Hospital of Brooklyn

Dear Parent(s)/Guardian(s):

We are happy to inform you that your child's school has a School Based Health Center (SBHC)! The SBHC is run by **SUNY Downstate Health Sciences University** and is part of the hospital's **Family Medicine** division. The SBHC is staffed by SUNY Downstate Health Sciences University licensed professionals consisting of medical and mental health providers.

Please know that your child can use the School-Based Health Center and see your other doctors as well. 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 primary doctor.

At the School Based Health Center, your child can receive the services listed below at **no cost** to you, regardless of insurance status. The SBHC bills insurance to support the model of care, however there are **no co-pays for you**, and **you do not receive a bill.**

School Based Health services include:

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests
- Immunizations
- Medical care, including treatment for acute and chronic conditions
- Age appropriate reproductive health care- *middle and high school sites only.*
- Health Education and Counseling
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- **Access to care during after-hours and or school closures with our Family Medicine Physicians at (917) 760-0846**

To register your child for the services at our School Based Health Center, please complete the following information on the attached enrollment form. Be sure to sign the Parent Consent packet documents:

1. **Parental Consent Form**
2. **Allergy/Medication Consent Form**
3. **Health Insurance Information Form**
4. **HIPAA Privacy**

If you can please attach the following documents when returning the parent consent packet:

- **A copy of your child's insurance card(s) (front and back).**
- **A copy of their immunization record.**
- **A copy of your child's most recent physical.**

Once completed, please return all forms to your child's school-based health center. If backpacking with your child, please call the clinic, so we can follow-up with your child directly. The SBHC is open Monday-Friday 8 a.m.- 4 p.m.

We look forward to meeting you and we look forward to providing health services to your child(ren). Feel free to visit us at the School Based Health Center for more information, or call us with questions.

Sincerely,
The SBHC Team

SUNY DOWNSTATE Health Sciences University
University Hospital of Brooklyn

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 ❑ Non-Binary

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 **SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY** 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 ____ ________________

Signature of Parent/Guardian **Date**

SUNY DOWNSTATE Health Sciences University
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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 **SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY** 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 — BOX 2
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 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 **SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY** 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

SUNY DOWNSTATE
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School Based Health Insurance Form

The School Based Health Center at your child's school provides comprehensive medical and mental health services regardless of insurance status at **no cost to you.** We do need your health insurance information for children seen at the clinic, in an effort to sustain the program operations. **This will not raise your premium or change your plan, and you will never be asked for a co-pay or any other out of pocket fees for the care received in the clinic.**

Thank you for supporting our work by updating your information!

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID # ___________________________

Does your child have Child Health Plus?

❑ No ❑ Yes: CHP # _________________________________

Which Plan?

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

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? _________

For more info regarding health coverage, please visit the NYS Health Office of Health Plan Marketplace at www.nystateofhealth.ny.gov

Does your child have other health insurance? (Please attach a copy of your child's insurance card.)

❑ No ❑ Yes

Health Plan: ____

Health Insurance Address: __________________________________

City: _________________ State: ________ Zip Code: ___________

Member ID/Policy Number: __________________________________

Group#: ____

Name of Insured: ____

Relationship to patient: _____________________________________

Insured's Date of Birth _______/___________/____________

Sex: ❑ F ❑ M Mo Day Year

Health Insurance Phone No: _________________________________

1.FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

I authorize payment of medical benefits to which the patient named below ("my child") is entitled directly to SUNY Downstate Health Sciences University School Based Health Program (SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY), to cover the cost of the care and treatment rendered to my child at SUNY Downstate Health Sciences University School Based Health Centers ("SBHC").

2. RELEASE OF INFORMATION

In the event my Insurer denies payment to SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY for services rendered to my child, I hereby give my consent to have an authorized representative of the Hospital contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to my child by the SBHC, which may be required in order for my insurer to reevaluate its decision to deny payment for such services. I authorize SUNY Downstate Health Sciences University School Based Health Program, my treating provider and their respective designees to use and disclose my child's health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying) to insurers and guarantors if needed for payment of SBHC and professional charges.

3. MEDICAID AND/OR OTHER INSURANCE CARRIER - 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 The SUNY Downstate Health Sciences University School Based Health Centers for any service(s) furnished to him/her by SBHC providers.

4. INSURANCE INFORMATION

I understand that The SUNY Downstate Health Sciences University School Based Health Centers will use various means to determine if my child has any insurance coverage including the Electronic Medicaid Eligibility Verification System or other holders of information about my child. I understand that these other sources of information will be used to confirm any insurance information I provided on the medical consent/registration form.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

______________________________________ ______________________________

NAME OF PARENT/GUARDIAN **RELATIONSHIP TO PATIENT**

X ______________________________________ ______/______/______

SIGNATURE OF PARENT/GUARDIAN **DATE**

SUNY DOWNSTATE Health Sciences University
University Hospital of Brooklyn

ALLERGY/MEDICATION CONSENT FORM

Child's Name: ________________________________ Date of Birth________________________

Does your child have any medical problems? ❑ No ❑Yes

❑ ADD/ADHD ❑ Asthma/Allergies ❑ Bleeding/Easy bruising ❑ Concussion ❑ Diabetes
❑ Headache/Migraine ❑ Heart/Murmurs ❑ Seizures ❑ Skin issues ❑ Stomach/GI ❑ Other:

Does your child take any medicines? ❑ No ❑Yes, list medicine(s):

Does your child have any known allergies to foods or medications? ☐ No ☐ Yes, list any allergies:

Foods/Medications: ________________________ **Symptoms/Reactions:** ________________________

________________________ ________________________

________________________ ________________________

The following **OVER-THE-COUNTER** medicines can be administered at the School Based Health Center:

- Ibuprofen (Advil/Motrin)
- Acetaminophen (Tylenol)
- Diphenhydramine (Benadryl)/Allergy medicine
- Eye wash
- Nasal Decongestant/Saline Drops

Bacitracin Ointment/A&D Ointment
Hydrocortisone 1% Cream (anti-itch)
Clotrimazole 1% Cream (anti-fungal)
Ear Drops
Loperamide (Imodium)/Maalox (stomach issues)

I give the NP/PA **PERMISSION** to administer over-the-counter medicine, as needed? ❑No ❑Yes

I would like to be notified **BEFORE** my child receives any over-the-counter medicine. ❑No ❑Yes

Contact Name ________________________ Contact Number________________________________

(If you request to be notified prior to your child receiving any medication, and we are unable to reach you, the medicine will NOT be given)

PLEASE NOTE: In an EMERGENCY, Benadryl/Prednisone/EPI-PEN/Albuterol may be given, even if unable to reach you.

I HAVE READ AND UNDERSTAND THE ABOVE ITEMS:

X ____ DATE ______/______/______
Signature of Parent/Guardian

HIPAA PRIVACY FORM
NOP ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.

Name of Patient/ Personal Representative: ____

I. Notice of Privacy

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by SUNY Downstate Medical Center and how you can obtain access to and control this information.
Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.downstate.edu.
We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

By signing below, I acknowledge that I received the Notice of Privacy Practices.

____ ___________
SIGNATURE OF PATIENT/ PERSONAL REPRESENTATIVE DATE

____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

For SUNY Downstate employee use only:
__ Patient would not acknowledge receipt of NPP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:
____
____
____

II. Individuals Involved in Care

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital or about the unfortunate event of your death.

Name: ___________________________	Name: ___________________________
Address: ___________________________	Address: ___________________________
___________________________	___________________________
___________________________	___________________________
Phone #: ___________________________	Phone #: ___________________________
Relation: ___________________________	Relation: ___________________________