MORRIS HEIGHTS HEALTHE CENTER
School Based Health Center Program
Adult Student General Consent
(18 years of age and older, who are parents, married, or legally emancipated)

***Health Care Service Provider address**:*
***Name of School(s)**:*

Please know that you 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 you can see your private doctor.

STUDENT INFORMATION

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Sex: ☐ Male ☐ Female **Grade**: _____
Student Address:_____
_____
City State Zip Code
Student email :_____

***Student Social Security Number:** _____
(* optional field: Used for insurance purposes only)

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Other _____

Do you have a regular doctor? ☐ No ☐ Yes, please list here
Name: _____
Telephone: _____
Address: _____

PARENT INFORMATION

Parent:
Last Name: _____ First Name: _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

Parent :
Last Name: _____ First Name: _____
Home/ Work Tel:_____
Cell Phone:_____
Email: _____

ADDITIONAL EMERGENCY CONTACT
Name:_____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

INDICATE THE PHARMACY YOU USE FOR PRESCRIPTIONS
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____

INSURANCE INFORMATION

Do you have Medicaid?
☐ No ☐ Yes: Medicaid ID # _____

Do you have Child Health Plus?
☐ No ☐ Yes: CHP # _____

Which Plan?
☐ Affinity ☐ Fidelis
☐ Healthfirst ☐ Empire BC/BS Health Plus
☐ Emblem Health ☐ Metro Plus
☐ Well Care ☐ United Healthcare

Do you have private health insurance through your parents or any other type of health insurance?
☐ No ☐ Yes, Health Plan: _____
Member ID/Policy Number: _____
Health Insurance Phone: _____

If you do not have 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: GENERAL 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 me to receive services provided by the MORRIS HEIGHTS HEALTH CENTER School-Based Health Center.
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 may have examined me.

X _____ _____
Signature of Student **Date**

BOX 2: HIPAA COMPLIANT GENERAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in box 2 on the 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 Student **Date**

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SCHOOL BASED HEALTH CENTER SERVICES — BOX 1

I consent to receive health care services provided by the State-licensed health professionals of MORRIS HEIGHTS HEALTH CENTER as part of the school health program approved by the New York State Department of Health. I understand that confidentiality between myself and the health provider will be ensured in specific service areas in accordance with the law, 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. 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/treatment, and referrals for abnormal results.
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.
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 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 my health and safety. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. You 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 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 MORRIS HEIGHTS HEALTH CENTER School-Based Health Center to release specific medical information on the student listed 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 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 Exams (Form CH-205, or equivalent such as sports physicals, etc.)
- * Immunizations (required /recommended)
- *Vision and Hearing Screening
- * 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 infection/STI infection/STI 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.