

**Please email completed form to secure mailbox at: JamesKieranSBHC@institute.org

The Institute for Family Health
School-Based Health Program
www.institute.org



It's fast and easy for your child to receive health care services through the James Kieran Middle School Campus School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that the James Kieran Middle School Campus will soon have a School Based Health Center (SBHC)! The SBHC is run by The Institute for Family Health and is part of the Mount Sinai Hospital division. The SBHC is staffed by licensed professionals consisting of medical and mental health.

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 is allowed to bill insurance, however there are **no co-pays for you**, and **you do not receive a bill**.

School Based Health Center 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
- Health Education and Counseling
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Access to care 24 hours/day, 7 days/week

To register your child for the services of our School Based Health Center, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

☺ **Parental Consent Form**

☺ **Basic Health History**

Give the completed forms to your school's parent coordinator or bring it directly to the School Based Health Center.

The School Based Health Center is located in room 142 of your child's school and will be open every school day between the hours of 8:30 am – 4:00 pm. You can call us at (347)821-3270 for more information.

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

Sincerely,

Elizabeth Ring, CPNP
Medical Director
School Based Health Centers
The Institute for Family Health

Richard Hallenbeck
Principal
JHS 123 – The Bronx Urban Community Magnet School

Tara Joye
Principal
The School for Inquiry and Social Justice

The Institute for Family Health School Based Health Center
Parental Consent Form

***Please email completed form to secure mailbox at:
JamesKieranSBHC@institute.org

Health Care Service Provider Address: 1025 Morrison Avenue, Room 142, Bronx, NY 10472
Telephone: (347)821-3270 Fax: (347)821-3271

Name of School: **The School for Inquiry and Social Justice**

JHS 123 The Bronx Urban Community Magnet School

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
<p>Student Last Name: _____</p> <p>Student First Name: _____</p> <p>Date of Birth: _____ / _____ / _____ <i>Month Day Year</i></p> <p>Student Address: _____ _____ <i>City State Zip Code</i></p> <p>Student email: _____</p> <p>*Student Social Security Number: _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Grade _____</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>List the student's regular doctor, if they have one? Name: _____ Telephone: _____ Address: _____</p> <p>Indicate the Pharmacy where we can send prescriptions. Pharmacy _____ Pharmacy Address: _____ Pharmacy Tel: _____</p> <p>*Indicates optional field: Used for insurance purposes only</p>	<p>Parent/ Legal Guardian: Last Name: _____ First Name: _____ Home/Work Tel: _____ Cell Phone: _____ Email: _____</p> <p>Parent/Legal Guardian: Last Name: _____ First Name: _____ Home/Work Tel: _____ Cell Phone: _____ Email : _____</p> <p>If legal guardian , relationship to the student: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____ Home/Work Tel: _____ Cell: _____ Email: _____</p> <p>Preferred Language of Parent/ Guardian: _____</p> <div style="background-color: #cccccc; text-align: center; padding: 2px;">ADDITIONAL EMERGENCY CONTACT</div> <p>Name: _____ Relationship to Student: _____ Home or Work Tel: _____ Cell: _____</p>

INSURANCE INFORMATION	
<p>Does your child have Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes: Medicaid ID # _____</p> <p>Does your child have Child Health Plus? <input type="checkbox"/> No <input type="checkbox"/> Yes: CHP # _____</p> <p>Which Plan? <input type="checkbox"/> Affinity <input type="checkbox"/> Fidelis <input type="checkbox"/> Healthfirst <input type="checkbox"/> Empire BC/BS Health Plus <input type="checkbox"/> Emblem Health(HIP/GHI) <input type="checkbox"/> Metro Plus <input type="checkbox"/> WellCare <input type="checkbox"/> United Healthcare</p>	<p>Does your child have other health insurance <input type="checkbox"/> No <input type="checkbox"/> Yes, Health Plan: _____ Member ID/Policy Number: _____ Health Insurance Phone: _____</p> <p>If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes What is the best time to contact you? _____</p>

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 JAMES KIERAN CAMPUS 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 _____

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 THE INSTITUTE FOR FAMILY HEALTH JAMES KIERAN School-Based Health Center 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 JAMES KIERAN CAMPUS 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:

- * New Entrant Exam (Form CH-205)
- * Immunizations (required /recommended)
- * Vision and hearing screening results
- *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 (NOT including HIV 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

NOTE: This School Based Health Center Parental Consent Form has been approved by DOE/OSH

Dear Parent/Guardian: Your child's health is important to us. To help the Health Center better understand their healthcare needs, and/or to care for them in case of an emergency, please fill out this brief and confidential health history form.

Child's Name				Date of Birth (mm/dd/yyyy)			School			Grade			
Your child's health history				Yes	No	Not Sure	The NYS Dept of Health requires these questions about risk for tuberculosis and lead intoxication:				Yes	No	Not Sure
Does your child have any allergies to medications? If yes, what are they:							Has your child ever had tuberculosis or a positive skin test for tuberculosis? If yes, at age:						
Does your child have any food allergies? If yes, what are they:							Has your child been around anyone with tuberculosis (TB) disease? If yes, when? Who?						
Have there been any changes in your child's health in the past year? If yes, what are they:							Does your child have a close contact or live with a person who has a positive TB skin test? If yes, when? Who?						
Does your child take any medications regularly? If yes, what are they:							Has your child lived in the US for less than 5 years? If yes, where else have they lived:						
Has your child ever had chicken pox before? If yes, at age:							Has your child travel outside the US for more than one month at a time? If yes, where?						
Has your child ever been hospitalized or had surgery? If yes, for what?							Has your child traveled to, or used products (like glazed pottery, folk remedies, cosmetics, food, spices) imported from Haiti, Mexico, Pakistan, the Dominican Republic, or Bangladesh?						
Does your child have a doctor you go to and like outside of school? When was their last complete health exam/physical? Date:							Who does the child live with most of the time?						
Does your child have a dentist you go to and like outside of school? When was their last dental visit? Date:							In the past year, have there been any major changes in your family? Eg: Marriage, Divorce, Deaths, New School, Serious Illness, Births, etc.						
Does your child have any health conditions or issues:				Yes	No	Not Sure	Have any other family members, living or dead, had any of the following problems? Check all that apply.						
Allergies (seasonal/environmental)							NA	Mother	Father	Sibling	Grand-parent		
Anxiety/depression (circle one or both if yes)													
Asthma													
Attention Defecit Disorder													
Diabetes													
Obesity													
Other:													
<p>If your child comes to the Health Center for a small pain (headache/toothache/menstrual cramps) would you like to be called BEFORE your child is given an over-the-counter pain-reliever (like Tylenol/Motrin unless they are allergic)?</p> <p style="text-align: center;">Circle one: Yes No</p>													
Name				Date (mm/dd/yyyy)									
Signature													
Relationship to child													

Please call the health center with any questions. *Thank you!*



HEALTH CARE AND MORE

FOR YOU AND YOUR FAMILY



- Physical exams
- Care for chronic conditions
- Medications and prescriptions
- Help with insurance enrollment
- Sports clearance
- Pre-employment
- Immunizations
- Hearing and vision screenings
- Reproductive health care
- Mental health services
- Referrals to other providers



We're here every day school is open, from 8:30am-4:00pm. Enroll your child in quality, no-cost, confidential school-based health services today.

NO ONE IS TURNED AWAY.

JAMES M. KIERAN CAMPUS SCHOOL-BASED HEALTH CENTER

For students at:

- **J.H.S. 123 – The Bronx Urban Community Magnet School**
- **M.S. 337 – The School for Inquiry and Social Justice**

1025 Morrison Ave, Room 142, Bronx, NY 10472

(347) 821-3270

Fax: (347) 821-3271

For health care for children and adults, visit a health center below or go to institute.org/locations for more locations.

STEVENSON FAMILY HEALTH CENTER

731 White Plains Road
Bronx, NY 10473
(718) 589-8775

WALTON FAMILY HEALTH CENTER

1894 Walton Avenue
Bronx, NY 10453
(718) 583-3060

HARLEM FAMILY HEALTH CENTER

1824 Madison Avenue
New York, NY 10035
(844) 434-2778

www.institute.org

