**Please email completed form to secure mailbox at: PS57SBHC@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 PS/MS 57 James Weldon Johnson Leadership Academy School-Based Health Center!

Dear Parent or Guardian:

We are happy to inform you that PS/MS 57 James Weldon Johnson Leadership Academy has 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 The Institute for Family Health licensed professionals consisting of medical, mental health and dental 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 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
- Dental Services

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 Questionnaire**

Please send completed forms to PS57SBHC@institute.org or give to your Parent Coordinator or directly to the School-Based Health Center located on the 1st floor, room 122.

The School Based Health Center which is located on the 1st floor of your child's school is open every day the school is open, between the hours 8:30am-4:00 pm.

We look forward to meeting you and we look forward to providing health services to your child. Feel free to visit us at the PS/MS 57 School-Based Health Center on the 1st floor or call us at (646) 838-6356 for more information.

Sincerely,

Elizabeth Ring, CPNP
Pediatric Nurse Practitioner
Medical Director, PS/MS 57
The Institute for Family Health

Rev: 4/19/18

***Please email completed form to secure mailbox at: PS57SBHC@institute.org

NYC Department of Education School Health Program
Parental Consent Form

Health Care Service Provider address: *176 East 115th Street, Room 122, New York, NY 10029 (646) 838-6356*

Name of School(s)*: PS/MS 57 James Weldon Johnson Leadership Academy School-Based Health Center*

Please know that your child can use the PS/MS 57 James Weldon Johnson Leadership Academy 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
❑ Healthfirst
❑ Emblem Health(HIP/GHI)
❑ WellCare
❑ Fidelis
❑ Empire BC/BS Health Plus
❑ Metro Plus
❑ 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 THE INSTITUTE FOR FAMILY HEALTH 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**

NYC Department of Education School Health Program
Parental Consent Form

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 SBHC 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 INSTITUTE FOR FAMILY HEALTH 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

The Institute for Family Health

BASIC HEALTH HISTORY

School-Based Health Program

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
Does your child have any allergies to medications? If yes, what are they:			
Does your child have any food allergies? If yes, what are they:			
Have there been any changes in your child's health in the past year? If yes, what are they:			
Does your child take any medications regularly? If yes, what are they:			
Has your child ever had chicken pox before? If yes, at age:			
Has your child ever been hospitalized or had surgery? If yes, for what?			
Does your child have a doctor you go to and like outside of school? When was their last complete health exam/physical? Date:			
Does your child have a dentist you go to and like outside of school? When was their last dental visit? Date:			

Does your child have any health conditions or issues:	Yes	No	Not Sure
Allergies (seasonal/environmental)			
Anxiety/depression (circle one or both if yes)			
Asthma			
Attention Defecit Disorder			
Diabetes			
Obesity			
Other:			

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)?

Circle one: Yes No

Name	Date (mm/dd/yyyy)
Signature	
Relationship to child	

The NYS Dept of Health requires these questions about risk for tuberculosis and lead intoxication:	Yes	No	Not Sure
Has your child ever had tuberculosis or a positive skin test for tuberculosis? If yes, at age:			
Has your child been around anyone with tuberculosis (TB) disease? If yes, when? Who?			
Does your child have a close contact or live with a person who has a positive TB skin test? If yes, when? Who?			
Has your child lived in the US for less than 5 years? If yes, where else have they lived:			
Has your child travel outside the US for more than one month at a time? If yes, where?			
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?			

Who does the child live with most of the time?

In the past year, have there been any major changes in your family?
Eg: Marriage, Divorce, Deaths, New School, Serious Illness, Births, etc.

Have any other family members, living or dead, had any of the following problems? Check all that apply.	NA	Mother	Father	Sibling	Grand-parent
Asthma					
Blood disorders/sickle cell anemia					
Mental health issue (depression/anxiety)					
Diabetes					
Heart attack or stroke before age 50					
High blood pressure					
High cholesterol					
Obesity					
Smoking tobacco cigarettes/cigars					
Other:					

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

THE INSTITUTE FOR FAMILY HEALTH

SCHOOL-BASED HEALTH CENTER

The Institute for Family Health **School-Based Health Program**

EL HISTORIAL DE SALUD BÁSICO

Estimado Padre/Madre/Guardián: La salud de su niño es importante. Para ayudar al Centro de Salud a entender mejor sus necesidades de salud, y/o para cuidar de su niño en caso de emergencia, complete este breve y confidencial formulario.

Nombre del niño	Fecha de nacimiento	Escuela	Grado

El historial de salud de su niño	Sí	No	No estoy seguro
¿Tiene su niño alguna alergia a los medicamentos? De ser así, ¿cuáles son?			
¿Tiene su niño alguna alergia a los alimentos? De ser así, ¿cuáles son?			
¿Ha habido cambios en la salud de su niño en el año pasado? De ser así, ¿cuáles son?			
¿Toma su niño algún medicamento regularmente? De ser así, ¿cuáles son?			
¿Alguna vez ha tenido su niño varicela? De ser así, ¿a qué edad?			
¿Alguna vez ha sido su niño hospitalizado o ha tenido cirugías? De ser así, ¿para qué?			
¿Tiene su niño un doctor al que va y le gusta fuera de la escuela? ¿Cuándo fue la fecha de su último examen completo de salud/físico? Fecha:			
¿Tiene su niño un dentista al que va y le gusta fuera de la escuela? ¿Cuándo fue su última visita dental? Fecha:			

¿Tiene su niño alguna condición o problema de salud?	Sí	No	No estoy seguro
Alergias (estacionales/ambientales)			
Ansiedad/depresión (marque uno o ambos)			
Asma			
Trastorno de Déficit de Atención			
Diabetes			
Obesidad			
Otro:			

Si su niño viene al centro de salud por un pequeño dolor (dolor de cabeza/de dientes/cólicos menstruales), ¿le gustaría que le llamáramos ANTES de que se le dé a su niño medicina para aliviar el dolor sin receta (como Tylenol/Motrin al menos que sea alérgico)? **Marque uno:** **Sí** **No**

Nombre	Fecha
Firma	
Relación con el niño	

El Dep de Salud de Estado de NY requiere estas preguntas sobre el riesgo de tuberculosis e intoxicación por plomo:	Sí	No	No estoy seguro
¿Alguna vez ha tenido su niño tuberculosis o un examen de piel para tuberculosis positivo? De ser así, ¿a qué edad?			
¿Ha estado su niño alrededor de alguien con la enfermedad de tuberculosis (TB)? De ser así, ¿cuándo? ¿Quién?			
¿Tiene su niño un contacto cercano o vice con una persona que tiene un examen de piel para tuberculosis positivo? De ser así, ¿cuándo? ¿Quién?			
¿Ha vivido su niño en los Estados Unidos por menos de 5 años? De ser así, ¿dónde más ha vivido?			
¿Ha viajado su niño fuera de los Estados Unidos por más de un mes a la vez? De ser así, ¿a dónde?			
¿Ha viajado su niño, o ha usado cerámica glaseada, remedios caseros, cosméticos, alimentos, especias) importados de Haití, México, Pakistán, la República Dominicana, o Bangladesh?			

¿Con quién vive el niño?

¿En el año pasado, ha habido algunos cambios mayores en su familia? (Eg. matrimonio, divorcio, enfermedades graves, muertes, otro)

¿Algún familiar, vivo o muerto, ha tenido alguno de estos problemas? Marque todo lo que corresponda:	N/A	Madre	Padre	Hermano/a	Abuelo/a
Asma					
Desordenes de sangre/anemia falciforme					
Depresión/ansiedad					
Diabetes					
Ataque al corazón antes de los 50 años					
Presión arterial alta					
Colesterol alto					
Obesidad					
Fumar cigarros de tabaco/puros					
Otro:					

Por favor llame el centro de salud con cualquier pregunta. *¡Gracias!*

THE INSTITUTE FOR FAMILY HEALTH

SCHOOL-BASED HEALTH CENTER

HEALTH CARE AND MORE

FOR YOU AND YOUR FAMILY

THE INSTITUTE FOR FAMILY HEALTH

SCHOOL BASED HEALTH CENTER

- 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.

P.S. 57 JAMES WELDON JOHNSON SCHOOL-BASED HEALTH CENTER

176 East 115th Street
New York, NY 10029
(646) 838-6356
Fax: (212) 289-0428

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

THE INSTITUTE FOR FAMILY HEALTH AT 17TH STREET

230 West 17th Street
(between 7th & 8th Avenues)
New York, NY 10011
(212) 206-5200

HARLEM FAMILY HEALTH CENTER

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

STEVENSON FAMILY HEALTH CENTER

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

www.institute.org