

NYC Department of Education School Health Program School Parental Consent Form (Grades PK-8)

Intermediate School 220 _____ (School(s) Covered)
NYU Lutheran Family Health Center Network (NYU LFHCN) _____ (HCSP)
150 55th Street – Brooklyn, NY 11220 at: Intermediate School 220 _____ (HCSP Address)

Office Use Only

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
Student's Last Name: _____ Student's First Name: _____ Date of Birth: _____ / _____ / _____ <i>Month Day Year</i> Student's Social Security Number: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Grade _____ 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 _____ Student Address: _____ <i>City State Zip Code</i> Who is the student's regular doctor? Name: _____ Telephone: _____ Address: _____	Mother Last Name: _____ First Name: _____ Father Last Name: _____ First Name: _____ Legal Guardian, If Applicable Last Name: _____ First Name: _____ Relationship of legal guardian to student <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or Uncle <input type="checkbox"/> Other: _____ Contact Information for parent or guardian Home Tel: _____ Work Tel: _____ Beeper/Cell: _____ Additional Emergency Contact Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____ Beeper/Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes: Medicaid ID # _____ Does your child have Child Health Plus? <input type="checkbox"/> No <input type="checkbox"/> Yes: CHP # _____ Which Plan? <input type="checkbox"/> Affinity <input type="checkbox"/> Fidelis <input type="checkbox"/> Healthfirst <input type="checkbox"/> Health Plus Amerigroup <input type="checkbox"/> HIP <input type="checkbox"/> MetroPlus <input type="checkbox"/> WellCare <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other	Does your child have other insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes: Health Plan: _____ Member ID Number: _____ If your child does not have health insurance, would you like an In-Person Assistor authorized by the NY State of Health Marketplace to contact you to enroll into health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes What is the best time to contact you? _____
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PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

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 NYU LUTHERAN FAMILY HEALTH CENTER NETWORK (LFHCN) (HCSP) School-Based Health Center.

NOTE: 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 or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) _____ **Date** _____

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____
Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) _____ **Date** _____

**NYC Department of Education School Health Program
School Parental Consent Form**

Intermediate School 220 _____ (School(s) Covered)
NYU Lutheran Family Health Center Network (NYU LFHCs) _____ (HCSP)
150 55th Street – Brooklyn, NY 11220 at: Intermediate School 220 _____ (HCSP Address)

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of NYU LUTHERAN FAMILY HEALTH CENTER NETWORK (NYU LFHCN) (HCSP) 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. 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.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. 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**

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information 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 NYU LUTHERAN FAMILY HEALTH CENTER NETWORK (LFHCN) (HCSP) 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:

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| Information Required by Law or Chancellor's Regulation: | Information to Protect Health and Safety: |
| - New Entrant Exam (Form 211S) | - Conditions which may require emergency medical treatment (Form 103S) |
| - Immunizations | - Conditions which limit a student's daily activity (Form 103S) |
| - Vision and hearing screening results | - Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law). |
| - Tuberculin test results | - Health insurance coverage |

My signature on page 1 of this form also gives my consent to NYU LUTHERAN FAMILY HEALTH CENTER NETWORK (LFHCN) (HCSP) to contact other providers that have examined my child and to obtain insurance information.

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