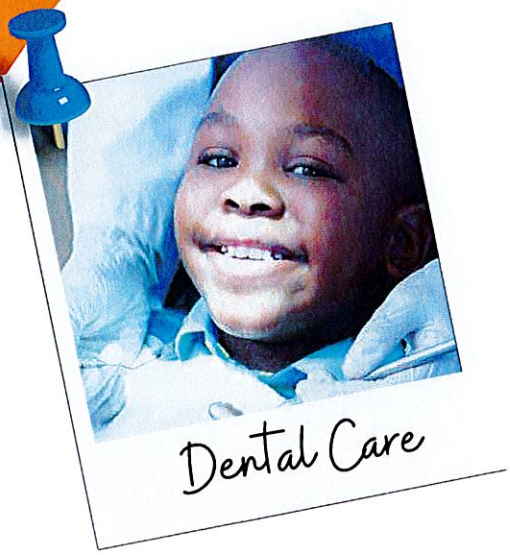
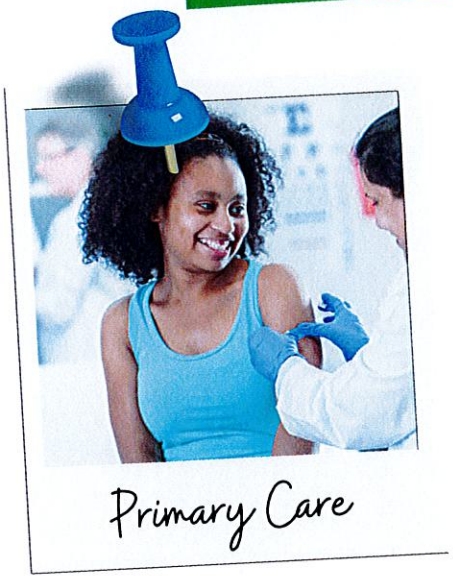
SCHOOL BASED HEALTH CENTER

CONSENT PACKET





The MHHC School Based Health Center Program (SBHC) is conveniently located in your child's school. Our SBHC does not replace your child's primary care physician, but rather, we work closely with them to provide continuity of care.

At our health center's, your child receives care and services that are provided at **NO COST** to you, regardless of insurance or immigration status. Students have easy access to:

- ✓ Primary Care Services
- ✓ Physical Exams
- ✓ Health Education Services
- ✓ Immunizations
- ✓ Behavioral Health Services
- ✓ Dental and Vision Services (at select locations)

MHHC School Based Health Center
2306 Walton Avenue
Bronx, NY 10453
718-716-4400

Return Form To Your SBHC location
OR via email at
sbhcquestions@mhhc.org

It's fast and easy for your child to receive health care services through the Morris Heights School-Based Health Center!

Dear Parent or Guardian:

We are happy to inform you that your child's school has a School Based Health Center (SBHC). The SBHC is staffed by licensed professionals consisting of medical and mental health providers from Morris Heights Health Center.

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. Additionally, if you have already completed a MHHC School Based Health Center Parental Consent Form at your previous school, your child is automatically enrolled and can access our services immediately.

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 can 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 and treatment for acute and chronic conditions
- Age-appropriate reproductive health care
- In-person or Remote Telehealth Visits
- Health Education and Counseling
- Mental Health Counseling Services
- Screening for vision, hearing, asthma, obesity, and other medical conditions
- Access to care 24 hours/day, 7 days/week
- Dental Services, including oral cleanings, sealants, fluoride varnish and Silver Diamine Fluoride applications

To register your child for the services of our School Based Health Center, please read and complete and sign the Registration information on the Parental Consent forms. The complete registration includes completing:

😊 **Parental Consent Form**
😊 **Medical History Form**

Give the completed forms to your Principal's Office or directly to the School Based Health Center. The completed forms can also be emailed directly to the School Based Program at: sbhcquestions@mhhc.org

The School Based Health Center at your child's school is opened every school day between the hours of 8:00am - 4:00pm.

We look forward to meeting you and to providing health services to your child. We invite you to visit us online at mhhc.org where you can take a virtual clinic tour, get more helpful information, educational materials and general program updates.

Feel free to give us a call at **(718) 483-1270 Ext 2471** for more information. We are here for you!

Yours in Health and Wellness,
Nicole Clarke – Director, SBHC Program
Dr. Sarmistha Mukherjee – Medical Director, SBHC Program

MORRIS HEIGHTS HEALTH CENTER
School Based Health Center Parental Consent Form

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

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 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:
☐ Grandparen ☐ Aunt/Uncle ☐ oster 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 MORRIS HEIGHTS HEALTH CENTER 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**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

MORRIS HEIGHTS HEALTH CENTER
School Based Health Center 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 _____ 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 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 MORRIS HEIGHTS HEALTH CENTER 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

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

Morris Heights Health Center School Based Health Program

Medical Health History Form

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

Child's Name	Date of Birth:	School:	Grade:

Your child's health history	**Yes**	**No**	**Not Sure**
Does your child have any allergies to any medicine? If yes, for what?			
Does your child have any allergies to any food? If yes, for what?			
Do you have any concerns about your child? If yes, for what?			
Does your child take any medications every day? If yes, for what? If			
Has your child ever been admitted to the hospital or had any surgeries? If yes, for what?			
Does your child have a regular doctor outside of school? If yes, who? _____ Date of last physical:			
Does your child have a regular doctor outside of school? If yes, who? _____ Date of last physical: _____			
Is your child exposed to marijuana, cigarettes, e-cigarettes, vaping, or e-cigarettes?			

Name of Parent/Guardian:	**Date**
Signature:	
Relationship to child:	

Who does the child live with most of the time? (Please circle)

Parents Grandparents Mother only Father only Guardian Sibling Foster parents Others: _____

In the past year, have there been any major changes in your family? (Please circle)

Marriage Separation Divorce Moving Loss of job New School Births Serious Illness Deaths Other: _____

Does your child have or ever had any of the following?	**Yes**	**No**	**Not Sure**
Allergies			
Anxiety/Depression			
Attention Deficit/Hyperactivity Disorder (ADHD)			
Asthma			
Diabetes			
Heart Problems			
Problems in school			
Seizures			
Sickle Cell Disease or Trait			

Have any family members ever had any of the following problems?	**Mother**	**Father**	**Sibling**	**Grand-parent**	**N/A**
Asthma					
Blood Disorders/Sickle Cell Disease					
Mental Health Problems					
Diabetes					
Heart attack or Stroke before age 50					
High blood pressure					
High Cholesterol					
Cancer					
Other:					

Please call the clinic with any questions.
Thank you!

FOR OFFICE USE ONLY:	
Reviewed by:	Date:

Revised 7/2023

Morris Heights Health Center
School Based Health Center

Summary of Your Privacy Rights

This summary describes Your Rights and Our Responsibility regarding the privacy of your medical information. A detailed copy of our Notice of Privacy Practices is available upon request.

Your privacy is very important to us, and we are committed to protecting Health Information that identifies you. We are required by law to maintain the privacy of your Health Information. Special privacy protections apply to HIV status, alcohol and substance abuse, mental health, and genetic information.

How we may use your disclosed health information:

For treatment

MHHC may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in your care. We may also disclose Health Information to people outside of MHHC who may be involved in your medical care.

For Health Care Operations

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes.

Other Uses and Disclosures

We will disclose medical information about you when required to do so by international, federal, state, or local law. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the Health Information is necessary for such functions or services. We may disclose Health Information for public health activities. We may disclose Health Information to a health oversight agency for audits, investigations, inspections, and licensure. Other uses and disclosures of Health Information not covered by this Notice or laws that apply to us will be made only with your written permission.

Your Rights Regarding Health Information About You

You have the right to inspect and copy Health Information that may be used to make decisions about your care. You may ask MHHC to correct your records if you believe they are incorrect or incomplete. You have the right to request a list of other persons or organizations to whom we have disclosed your Health Information. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment or health care operations. You may also have the right to request a limit on the Health Information we disclose about you to your health plan or to someone who is involved in your care. You have the right to request that we communicate with you about medical matters in a more confidential way or at a certain location. If there is improper access or breach, use or disclosure of your Health Information, we will notify you.

You have the right to a paper copy of our detailed Notice of Privacy Practices. Please ask a member of our health care staff or visit our website at www.mhhc.org. If you believe your privacy rights have been violated, you may file a complaint with Morris Heights Health Center or with the Secretary of the Department of Health and Human Services. To file a complaint with Morris Heights Health, call our Compliance Hotline at 718-299-2971.

Our Responsibilities

We will follow the duties and Privacy Practices describes in this notice. We will provide you with a copy. We are required by law to maintain the privacy and security of your Protected Health Information (PHI).