Montefiore School Health Program

http://www.montefiore.org/school-health-program

Dear Parent/Guardian:

Your child's school, in partnership with the Montefiore School Health Program, has a comprehensive health center that is different from the school nurse's office. The health center provides students with emergency care and first aid for minor injuries; physical exams for school, sports or working papers, confidential counseling & stress reduction, immunizations, asthma care, nutritional counseling, preventative dental services and more.

To enroll your child in the health center, please complete the enclosed forms and provide the following:

- Parental/Guardian Consent Form
- Basic Health History Form. **All information is kept confidential.**
- Insurance Form. **Please include copy of your child's insurance card(s) – front and back.**
- **Include a copy of your child's immunization record**

Health Center' s FAQs

What are our hours?
We are open school days: Monday – Friday 8:00 AM to 3:30 PM. Closed daily for a half-hour lunch. Please speak with a health center staff member for our assigned lunch time.

Who is on the staff?
Medical Provider(s), Mental Health Provider(s), Licensed Practical Nurse, Community Health Organizer and a Senior Clerk. Preventative and restorative dental services are currently available at certain High School Campus locations; preventative dental services are currently available at certain Elementary School Campus location.

Does my child need to be insured?
No, we provide services to your child regardless of their insurance coverage. We bill insurance carriers whenever possible to help cover program costs but we do not charge co-pays. Insurance coverage assists in facilitating referrals to sub-specialists and for diagnostic testing.

Am I responsible for co-pays?
No, we bill insurance carriers whenever possible to help cover our program costs but we do not charge co-pays. Insurance is also important to facilitate any referrals to sub-specialists and for diagnostic testing.

Does my child need to be a US citizen?
No, your child does not need to be a US citizen. We do not collect information on citizenship status.

Does my child need to change their regular health care provider?
No, you child may keep their doctor. We work with and communicate with your child's health care providers, specialists or mental health providers whether they are Montefiore or non-Montefiore providers.

We are committed to the health of the students and invite you to share your questions or concerns with us.

Sincerely,

The Montefiore School Health Program

Montefiore School Health Program
School Parental Consent Form

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of Montefiore Medical 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) among other methods], testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. *FOR ADOLESCENT STUDENTS*: 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.
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

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 Montefiore Medical 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:
- New Entrant Exam (Form 211S)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Health insurance coverage

My signature on Page 3 of this form gives my consent to Montefiore Medical Center 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

Montefiore School Health Program

Insurance Form

OSIS #: _____ Office Use Only
Medical Record No. _____

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Student's Middle Initial: _____

Date of Birth:_____/_____/_____
Month Day Year

Student's Social Security Number: _____
(Optional)

Student's School: _____

Gender:_____ **Grade:** _____

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

Preferred Language: _____

Student Address:_____

Apt:#_____ _____ _____ _____
City State Zip Code

Does the student have a regular doctor (PCP)? ❑ Yes ❑ No

Name: _____

Address: _____

Tel: _____

Does the student have a regular dentist? ❑ Yes ❑ No

Name: _____

Address: _____

Tel: _____

PARENT/GUARDIAN INFORMATION

Mother's Name

Last: _____ First : _____

DOB: _____/_____/_____
Month Day Year

Father's Name

Last: _____ First : _____

DOB: _____/_____/_____
Month Day Year

Name of Legal Guardian, If Applicable

Last: _____ First : _____

DOB: _____/_____/_____
Month Day Year

Relationship of legal guardian to student

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Proof of guardianship _____

Contact Information for parent or guardian

Home Tel: _____Work Tel:_____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____Work Tel: _____

Cell: _____

Is this student in Foster Care: ❑ Yes ❑ No

Foster Care Agency Name:_____

Address of Agency:_____

Case Worker Name:_____

Phone number:_____

BOX 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign box 1 and 2 to complete enrollment

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 Montefiore Medical Center 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) **Print** **Date**

Relationship:_____

BOX 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information. 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) **Print** **Date**

Relationship:_____

Montefiore School Health Program

Insurance Form

Name of Student_____

Date of Birth:_____/_____/_____
Month Day Year

Office Use Only
Medical Record No:_____

The Montefiore School Based Health Centers provide services to all students who are registered to receive services at **no cost** to the student or his/her family.

- In order to cover our program costs, we do bill Medicaid and other insurance carriers to receive payments.
- You may receive a notice called an Explanation of Benefits (EOB) from your insurance carrier with information regarding the services billed and the payments that have been approved.
- You **will not** receive a bill from The Montefiore School Based Health Program to pay for any services provided at The Montefiore School Based Health Centers.

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID #_____

Does your child have Child Health Plus?

❑ No ❑ Yes: CHP ID#_____

Which Plan?

❑ Affinity ❑ UHC Community Plan ❑ Empire BCBS Healthplus

❑ Fidelis ❑ HIP ❑ Wellcare

❑ HealthFirst ❑ MetroPlus ❑ Emblem Health / GHI

❑ Other: _____

Does your child have Vision Insurance? ❑ No ❑Yes, complete below *or* attach a copy of your insurance card.

Vision Insurance Name:_____
Vision Insurance Address:_____
City:_____State:_____ Zip Code:_____
Policy #:_____
Group #:_____
Name of Insured:_____
Relationship to patient:_____
Insured's Date of Birth: _____/_____/_____ Sex: ❑ F ❑ M
Mo Day Year

If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a NY State approved low-income health insurance plan? ❑ Yes ❑ No

Does your child have other Health Insurance? ❑ No ❑Yes, complete below *or* attach a copy of your insurance card:

Health Insurance Name:_____
Health Insurance Address:_____
City:_____State:_____ Zip Code:_____
Policy #:_____
Group #:_____
Name of Insured:_____
Relationship to patient:_____
Insured's Date of Birth: _____/_____/_____ Sex: ❑ F ❑ M
Mo Day Year

Does your child have Dental Insurance? ❑ No ❑Yes, complete below *or* attach a copy of your insurance card.

Dental Insurance Name:_____
Dental Insurance Address:_____
City:_____State:_____ Zip Code:_____
Policy #:_____
Group #:_____
Name of Insured:_____
Relationship to patient:_____
Insured's Date of Birth: _____/_____/_____ Sex: ❑ F ❑ M
Mo Day Year

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT
I authorize payment of medical benefits to which the patient named below ("my child") is entitled directly to The Montefiore School Based Health Centers, to cover the cost of the care and treatment rendered to my child at The Montefiore School Based Health Centers ("SBHC").

2. RELEASE OF INFORMATION
In the event my Insurer denies payment to The Montefiore School Based Health Centers for services rendered to my child, I hereby give my consent to have an authorized representative of the Hospital contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to my child by the SBHCs, which may be required in order for my insurer to reevaluate its decision to deny payment for such services.
I authorize The Montefiore School Based Health Centers, my treating provider and their respective designees to use and disclose my child's health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying) to insurers and guarantors if needed for payment of SBHC and professional charges.

3. MEDICAID AND/OR OTHER INSURANCE CARRIER – RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS
I certify that the insurance information given by me regarding my child is correct. I authorize any holder of medical or other information about my child to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which my child has coverage any information needed for this or a related claim. I request that payment of authorized benefits be made on my child's behalf to The Montefiore School Based Health Centers for any service(s) furnished to him/her by SBHC providers.

4. **INSURANCE INFORMATION**
I understand that The Montefiore School Based Health Centers will use various means to determine if my child has any insurance coverage including the Electronic Medicaid Eligibility Verification System or other holders of information about my child. I understand that these other sources of information will be used to confirm any insurance information I provided on the medical consent/registration form.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____
NAME OF PARENT RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE
(or student if 18 years or older or otherwise permitted by law)

Montefiore School Health Program

Basic Health History

Childs Name	DOB (Mo/Day/Year)	Grade	School

Dear Parent/Guardian: Your child's health is important to us. **To better understand your child's healthcare needs, the Montefiore School Health Program endeavors to conduct an annual Brief Health Assessment on every child who is enrolled in the school-based health center for services. This includes measurement of height, weight and blood pressure, review of a child's immunization record and documentation of a child's medical home.** This assessment does not replace the annual comprehensive Health Assessment done by your child's Primary Care Provider. If your child does not have a Primary Care Provider and/or does not have health insurance, you may request a comprehensive Health Assessment (that is, a "physical") at the school-based health center. The Montefiore School Health Program utilizes the same electronic health record used at Montefiore Medical Center, allowing us to communicate with any Montefiore provider.

We will always inform you if your child is ill and needs to leave school or seek urgent care. In order to do this, please inform us if your contact information changes. To help the School Health team be informed of your child's health needs for ongoing care and in case of emergency, please answer the following questions.

Has your child had any serious or chronic health problems?	**No**	**Yes**
Asthma		
Depression of Anxiety (circle on or both, if yes)		
Overweight or Obesity		
Other Chronic Conditions (Diabetes, Sickle Cell, etc)		
Was your child ever diagnosed with a heart murmur?		
Does your child take any medications regularly? **If yes, please specify name(s) and regimen(s)**		
Has your child ever been hospitalized or had surgery? **If yes, for what?**		
Has your child ever had chicken pox disease? **If Yes, Age_____ Yrs._____**		
Allergies to medications and food?	**No**	**Yes**
Is your child allergic to any medications? **If yes, please specify:**		
Is your child allergic to any foods? **If yes, please specify:**		
If yes, does your child have an Epi-pen?		

The NYS Department of Health requires us to ask the following questions about risk for tuberculosis and risk for lead intoxication.	**No**	**Yes**
Has your child ever had tuberculosis or a positive skin test for tuberculosis? **If Yes, Age_____ Yrs_____**		
Has your child been exposed to anyone with tuberculosis (TB) disease? **If Yes, When_____ Who_____**		
Does your child have close contact or live with a person who has a positive TB skin test? **If Yes, When?_____**		
Has your child lived in the United States for less than 5 years? **If Yes, where?_____**		
Has your child traveled outside the US for more than one month? **If Yes, Age_____ Where?_____**		
Has your child traveled to, or used products (glazed pottery, folk remedies, cosmetics, foods, or spiced) imported from Haiti, Mexico, Dominican Republic, Pakistan, Bangladesh?		

Have any of family members, living or deceased had any of the following problems? Check all that apply.	**Mother**	**Father**	**Sibling**	**Grand parent**	**Other**
Asthma					
Diabetes Melitus					
Heart attack or stroke before age 45 years					
High Cholesterol					
Smoking tobacco cigarettes/cigars					
Other:					
Other:					
Deceased					

If your child comes to the school-based health center with minor pain or other minor symptoms, we will give one of the following medications, unless your child has a specific allergy

Acetaminophen (Tylenol) or Ibuprofen (Motrin) for pain-relief such as headache or menstrual cramps or tooth-related pain
Maalox for stomach ache or nausea
Pepto-bismol for diarrhea or upset stomach
Loratadine (Claritin) for seasonal allergies
Pseudoephedrine for cold symptoms

If you do not want your child to reveive any of these medications without speaking to the medical or dental provider first, please check the box below. If you check this box and we cannot reach you, your child will NOT be given any medication at this visit. ☐

We will always inform you if your child is ill and needs to leave school or seek urgent care. In order to do this, please inform us if your contact information changes.

Please indicate the **pharmacy** that is convenient for you, in order to electronically forward any needed prescriptions to the pharmacy. **Electronic prescriptions are now required.**

Pharmacy Name: _____

Pharmacy Address: _____

Date (Mo/Day/Year)	*Name*	*Signature*	*Relationship to child*