Dear Parent(s)/Guardian(s):

Greetings! SUNY Downstate Medical Center at Long Island College Hospital is offering health services at the School Based Health Center located in Room 209. Services are provided by the Certified Pediatric Nurse Practitioner, Licensed Clinical Social Worker, and Medical Assistant.

Your child can receive services in our center at no out of pocket cost to you. You will not be billed for these services, but it is important that you provide your health insurance information so that it can be billed.

School Based Health services include:

- Physical exams
- Prescriptions
- Medical care for asthma and diabetes
- Age appropriate reproductive health care
- Health education and counseling
- Mental health services
- Screening for vision, hearing, dental, asthma, obesity
- Screening and referral for health insurance

In order for your child to receive health services, a parent or legal guardian must read, complete, sign, and return the following forms:

1. NYC Department of Education School Health Program Consent Form
2. Over-the-counter Medication Consent Form
3. Health Insurance Information Form

Return your forms to the School Based Health Center – Room 209.

Sincerely,

Verona Rowe
Program Manager
School Based Health Program
SUNY Downstate Medical Center at Long Island College Hospital
(718) 780-2521

Kim Forrester-Dumont, DO
Medical Director
School Based Health Program
SUNY Downstate Medical Center at Long Island College Hospital
(718) 780-2515
### NYC Department of Education School Health Program

**School Parental Consent Form (Grades PK-8)**

**The Brooklyn New School**  
**SUNY Downstate Medical Center at Long Island College Hospital**  
610 Henry Street, Room 209, Brooklyn, NY 11231

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#### Office Use Only

<table>
<thead>
<tr>
<th><strong>STUDENT INFORMATION</strong></th>
<th><strong>PARENT/GUARDIAN INFORMATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student’s Last Name:</strong></td>
<td><strong>Mother</strong></td>
</tr>
<tr>
<td><strong>Student’s First Name:</strong></td>
<td><strong>Last Name:</strong></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td><strong>First Name:</strong></td>
</tr>
<tr>
<td><strong>/ /</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>Month</strong></td>
<td><strong>Father</strong></td>
</tr>
<tr>
<td><strong>Day</strong></td>
<td><strong>Last Name:</strong></td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td><strong>First Name:</strong></td>
</tr>
<tr>
<td><strong>Sex:</strong></td>
<td><strong>Legal Guardian, If Applicable</strong></td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td><strong>Last Name:</strong></td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td><strong>First Name:</strong></td>
</tr>
<tr>
<td><strong>Grade</strong></td>
<td><strong>Relationship of legal guardian to student</strong></td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td><strong>Grandparent</strong></td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td><strong>Aunt or Uncle</strong></td>
</tr>
<tr>
<td><strong>Black</strong></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td><strong>White</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>American Indian</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>Asian/Pacific Islander</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>Student's Social Security Number:</strong></td>
<td><strong>(Voluntary. If disclosed, this information will only be used for Health Insurance purposes).</strong></td>
</tr>
<tr>
<td><strong>Student Address:</strong></td>
<td><strong>Who is the student’s regular doctor?</strong></td>
</tr>
<tr>
<td><strong>City</strong></td>
<td><strong>Name:</strong></td>
</tr>
<tr>
<td><strong>State</strong></td>
<td><strong>Telephone:</strong></td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
<td><strong>Telephone:</strong></td>
</tr>
</tbody>
</table>

Who is the student’s regular doctor?

- **Name:**
- **Telephone:**
- **Address:**

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#### INSURANCE INFORMATION

<table>
<thead>
<tr>
<th><strong>Does your child have Medicaid?</strong></th>
<th><strong>Does your child have any other insurance?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Yes:</strong> Medicaid ID #</td>
<td><strong>Yes:</strong> Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Does your child have Child Health Plus?</strong></th>
<th><strong>Coverage Number:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td><strong>/ /</strong></td>
</tr>
<tr>
<td><strong>Yes:</strong> CHP #</td>
<td><strong>/ /</strong></td>
</tr>
</tbody>
</table>

Which Plan?

- **Affinity**
- **Neighborhood**
- **Amerigroup**
- **HIP**
- **Health Plus**
- **Other:**

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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 SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL 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. Your decision to grant consent is voluntary and may be revoked at any time. If you revoke consent, your revocation is not retroactive.

- **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.

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

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**PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT**
SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL 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.
10. Assessment of medical need for related services (e.g., occupational therapy, physical therapy, speech) recommended on your child’s Individualized Education Plan in connection with possible Medicaid claiming for these services.

PARENTAL CONSENT FOR RELEASE OF HEALTH AND STUDENT RECORD INFORMATION

My signature on page 1 of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

My signature also provides consent to the release from the School-Based Health Center to the NYC Department of Education of medical information as outlined below, and from the DOE to the SBHC of medical and student record information as outlined below, in order to meet regulatory requirements or assist in Medicaid and other insurance claiming, if applicable, or in connection with the student’s health and participation in school. I understand that this information will be protected 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 CH-205)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results

Information for Insurance Claiming Purposes:
- Health insurance coverage
- Individualized Education Program (IEP) information

Information Relating to Health and Student’s Participation in School:
- Conditions which may require emergency medical treatment (Form 1035)
- Conditions which limit a student’s daily activity (Form 1033)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Enrollment in School-Based Health Center

My signature on page 1 of this form also gives my consent to SUNY DOWNSTATE MEDICAL CENTER AT LONG ISLAND COLLEGE HOSPITAL to contact other providers that have examined my child and to obtain insurance information.

My questions about this form have been answered. I understand that I do not have to allow release of my child’s medical or student record 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.

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)

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT
HEALTH INSURANCE INFORMATION
PLEASE FILL OUT COMPLETELY

Please check one:
- Managed Care-Private Insurance
- Medicaid Managed Care
- Medicaid
- Private Insurance-Non Managed Care
- No Insurance

Insurance Company’s name and Complete Mailing Address

Name: ____________________________________________

Address: ____________________________________________

City       State       Telephone number

Address where claims are sent if different from insurance company’s address:

__________________________________________

Insured’s Name: ____________________________________________

Parent(s)/Guardian Name: ____________________________________________

Insured’s L.D.# or Social Security #:

Parent(s)/Guardian Social Security #:

Parent/Guardian Phone number: Work: _______ Cellphone: _______

Insured’s Policy#:

Employer’s Name: ____________________________________________

Employer’s Address: ____________________________________________

City: _______ State: _______ Telephone #: _______

Child’s Social Security#:

If you or your child has Medicaid, please provide the number in the spaces below

(Example: A B 1 2 3 4 5 C)
Allergy/Medication Form

Answers to the following questions will help the school-based health center to treat your child more effectively.

Does your child have any medical problems? Yes ___ No ___ if yes please explain

Does your child have asthma? Yes ___ No ___

Does your child have any known allergies to foods or medications? Yes ___ No ___

If yes please list:

<table>
<thead>
<tr>
<th>Food or Medication</th>
<th>Symptoms or Reactions to Food/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

The following over-the-counter medications can be administered on-site in the school-based health center.

- Tylenol
- Advil/Motrin
- Maalox
- Pepto-Bismol
- Kaolin-Pectin (antidiarrheal)
- Children’s Cold/Cough Syrup (Robitussin)
- Benadryl (Antihistamine)
- Dimetapp (Antihistamine)
- Sudafed (Nasal Congestant)
- Anbesol Gel
- Bacitracin Ointment
- Lotrimin 1% Cream (antifungal cream)
- Hydrocortisone 1% cream (mild steroid cream)

Please indicate whether the Nurse Practitioner or Physician has your permission to administer over-the-counter medication to your child when appropriate.

Yes ___ No ___

I would like to be notified before my child receives any medications Yes ___ No ___

If you would like to be notified before your child receives any medications please note that medication will be withheld until you can be contacted.

Parent/Guardian Name: ____________________________________________

Parent/Guardian Signature: ________________________________________

PLEASE SEE BACK SIDE OF PAGE FOR INSURANCE INFORMATION
SUNY DOWNSTATE Medical Center

HIPAA PRIVACY FORM
NOTICE OF PRIVACY ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.

Name of Patient/ Personal Representative: ____________________________

I. Notice of Privacy

You are entitled to our Notice of Privacy Practices describing how your health information can be used and disclosed by SUNY Downstate Medical Center Health Science Center at Brooklyn and how you can obtain access to and control this information. Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.downstate.edu. We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

By signing below, I acknowledge that I received the Notice of Privacy Practices.

SIGNATURE OF PATIENT/ PERSONAL REPRESENTATIVE DATE ____________________________

DESCRIPTION OF PERSONAL REPRESENTATIVE’S AUTHORITY

For SUNY Downstate employee (official) use only:

    _ Patient would not acknowledge receipt of NOP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:

                      ____________________________

                      ____________________________

                      ____________________________

II. Individuals Involved in Care

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital or about the unfortunate event of your death.

Name: ____________________________ Name: ____________________________

Address: ____________________________ Address: ____________________________

Phone #: ____________________________ Phone #: ____________________________

Relation: ____________________________ Relation: ____________________________
Dear Parent/Guardian:

Your child's record shows that he/she needs the following vaccine(s) (shots) in order to be up to date.

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>My child may NOT have this vaccine</th>
<th>I want my child to receive this vaccine (please sign your name).</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (Diphtheria, Tetanus, acellular Pertussis)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>DT (Diphtheria &amp; Tetanus)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Td (Tetanus &amp; Diphtheria)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tdap (Tetanus, Diphtheria, acellular Pertussis)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>IPV (Inactivated Polio Vaccine)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Varivax (Varicella, aka Chicken Pox)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Menactra (Meningococcal aka Meningitis)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>HPV (Human Papilloma Virus)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(series of 3 shots) *** optional</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hepatitis A (series of 2 shots) *** optional</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please answer the following questions:

1. Has your child ever had a bad reaction to a vaccine?
   ☐ Yes  ☐ No  ☐ I don’t know

2. Has your child ever had a "positive PPD" (test for tuberculosis)?
   ☐ Yes  ☐ No  ☐ I don’t know

3. Is your child allergic to eggs or chicken?
   ☐ Yes  ☐ No  ☐ I don’t know

4. Is your child allergic to latex?
   ☐ Yes  ☐ No  ☐ I don’t know

5. Is your child allergic to any antibiotics?
   ☐ Yes  ☐ No  ☐ I don’t know