



Abigail Wolfson, CPNP  
610 Henry Street, Room 209  
Brooklyn, NY 11231  
(718) 923-4750 Ext. 2093

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

## Page 1 of 2

## The Brooklyn New School

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

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

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

**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.
9. Annual health questionnaire/survey.
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: Information Relating to Health and Student's Participation in School:**

- New Entrant Exam (Form CH-205)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Enrollment in School-Based Health Center

**Information for Insurance Claiming Purposes:**

- Health insurance coverage
- Individualized Education Program (IEP) information

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)



**SUNY  
DOWNSTATE**

**Medical Center**

University Hospital of Brooklyn  
at Long Island College Hospital

**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: \_\_\_\_\_

Last Name First Name Middle Initial Date of Birth

Parent(s)/Guardian Name: \_\_\_\_\_

Last Name First Name Middle Initial Date of Birth

Insured's I.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: \_\_\_\_\_

#### Food or Medication

1. \_\_\_\_\_
2. \_\_\_\_\_

#### Symptoms or Reactions to Food/Medication

- \_\_\_\_\_
- \_\_\_\_\_

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**



**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](http://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: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_



**SUNY  
DOWNSTATE**  
Medical Center

University Hospital of Brooklyn  
at Long Island College Hospital

LICH School Based Health Center  
BNS/BCS  
610 Henry Street, Room 209  
Brooklyn, NY 11231  
(718) 923-4750 ext. 2091

Date: \_\_\_\_\_

Child's Name: Tiannah Miller

Child's DOB: 10/02/04

Dear Parent/Guardian:

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

Vaccine Name	My child may NOT have this vaccine	I want my child to receive this vaccine (please sign your name)
<input type="checkbox"/> DTaP (Diphtheria, Tetanus, acellular Pertussis)	<input type="checkbox"/>	
<input type="checkbox"/> DT (Diphtheria & Tetanus)	<input type="checkbox"/>	
<input type="checkbox"/> Td (Tetanus & Diphtheria)	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Tdap (Tetanus, Diphtheria, acellular Pertussis)	<input type="checkbox"/>	
<input type="checkbox"/> IPV (Inactivated Polio Vaccine)	<input type="checkbox"/>	
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/>	
<input type="checkbox"/> Varivax (Varicella, aka Chicken Pox)	<input type="checkbox"/>	
<input type="checkbox"/> Menactra (Meningococcal aka Meningitis) *** optional	<input type="checkbox"/>	
<input type="checkbox"/> HPV (Human Papilloma Virus) (series of 3 shots) *** optional	<input type="checkbox"/>	
<input type="checkbox"/> Hepatitis A (series of 2 shots) *** optional	<input type="checkbox"/>	

Please answer the following questions:

- Has your child ever had a bad reaction to a vaccine?  
☐ Yes      ☐ No      ☐ I don't know
- Has your child ever had a "positive PPD" (test for tuberculosis)?  
☐ Yes      ☐ No      ☐ I don't know
- Is your child allergic to eggs or chicken?  
☐ Yes      ☐ No      ☐ I don't know
- Is your child allergic to latex?  
☐ Yes      ☐ No      ☐ I don't know
- Is your child allergic to any antibiotics?  
☐ Yes      ☐ No      ☐ I don't know