Mount Sinai Hospital *Pediatric School-Based Health Center Program*

It's fast and easy for your child to receive health care services through the Mount Sinai Hospital School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that PS 38/ Harlem Prep Middle School has a School-Based Health Center (SBHC)! The SBHC is run by The Mount Sinai Hospital and is part of the hospital Pediatrics division. The SBHC is staffed by Mount Sinai Hospital licensed professionals consisting of medical and mental health providers.

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.

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 is allowed to 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, including treatment for acute and chronic conditions
- Age-appropriate reproductive health care
- Health Education and Counseling
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Access to care 24 hours/day, seven days/week

To register your child for the services of our School-Based Health Center, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

- ☺ **Parental Consent Form**
- ☺ **Medical History Form**
- ☺ **Authorizations and Agreements Form**
- ☺ **NOPP**

Give the completed forms directly to the School-Based Health Center in room 156.

The School-Based Health Center is located in room 156 of your child's school and is open every school day between the hours of 8:00 am – 4:00 pm.

We look forward to meeting you, and we look forward to providing health services to your child. Feel free to visit us at the School-Based Health Center in room 101 or call us at 212-987-9295 for more information.

Sincerely,

Sharon M Edwards MD
Director, SBHC
Susan Zylbert MD
Medical Director
Mount Sinai Hospital

Carlina Barton-Santos and Andre Geddes
Principal (s)
PS 38 and Harlem Prep Middle School

Rev: 4/19/18

Mount Sinai Hospital 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:
☐Grandparent ☐ Aunt/Uncle ☐Foster 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 MOUNT SINAI HOSPITAL 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**

Mount Sinai Hospital 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 THE MOUNT SINAI 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. 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 MOUNT SINAI HOSPITAL 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

Mount Sinai Hospital *School Based Health Centers*

PATIENT NAME _____

DATE OF BIRTH ____/____/____

OFFICE USE ONLY

MRN/GENDER _____

MEDICAL HISTORY FORM (6TH – 12TH GRADE)

PAST MEDICAL HISTORY

In what hospital was your child born? _____ Birth Weight _____

Did your baby go home with you? ☐ Yes ☐ No

Has your child ever had an operation? ☐ Yes ☐ No

Has your child had to stay in the hospital overnight? ☐ Yes ☐ No

If so, for what condition? _____

What hospital(s)? _____ Date(s) _____

Has your child ever had a serious injury? ☐ Yes ☐ No

Has your child had any of the following conditions?

☐ Allergies ☐ Anemia ☐ Asthma ☐ Bleeding problem

☐ Chicken Pox ☐ Diabetes ☐ Eczema ☐ Heart condition

☐ Kidney problem ☐ Measles ☐ Pneumonia ☐ Seizures

☐ Tuberculosis ☐ Other (specify) _____

Do they have any allergies? (medication, food, etc.)? ☐ Yes ☐ No

If Yes, list allergies: _____

Has your child seen the dentist in the past year? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

When was their last tuberculosis (PPD) test? _____

When was their last tetanus shot? _____

Has your child left the U.S. in the past five years? ☐ Yes ☐ No

If Yes, where did they go? _____

FAMILY HISTORY

Who does your child live with?

☐ mother ☐ stepmother ☐ grandmother ☐ aunt(s) ☐ sister(s) ☐ niece ☐ foster parent

☐ father ☐ stepfather ☐ grandfather ☐ uncle(s) ☐ brother(s) ☐ nephew ☐ cousin(s)

List brothers or sisters whom they do not live with: _____

Do you live in a(n) ☐ Apartment? ☐ Private house? ☐ Shelter/Hotel?

Do any family members (including grandparents, aunts, uncles, cousins, etc.) have any of the following conditions?

☐ Allergy/Hay fever ☐ Alcohol abuse ☐ Anemia/Bleeding issues ☐ Asthma

☐ Cancer ☐ Diabetes ☐ Drug use ☐ Emotional problems

☐ Heart problems ☐ High blood pressure ☐ High cholesterol ☐ HIV/AIDS

☐ Kidney problems ☐ Learning problems ☐ Obesity ☐ Seizures

☐ Stroke ☐ Tuberculosis (TB) ☐ Other _____

SCHOOL HISTORY

What school does your child attend? _____ Grade? _____

Has he/she ever been left back? ☐ Yes ☐ No Is he/she in special ed? ☐ Yes ☐ No

Does he/she have any problems with school work (failing, poor attendance)? _____

Does he/she have any behavioral problems or concerns? _____

What plans does he/she have for the future? _____

PERSONAL HEALTH

Has your child have (or ever had) a problem with any of the following?

☐ Acne	☐ Bleeding	☐ Trouble breathing
☐ Broken bones (fractures)	☐ Chest pains	☐ Constipation
☐ Diarrhea	☐ Dizzy or fainting spells	☐ Eyes
☐ Wear glasses	☐ Frequent headaches	☐ High blood pressure
☐ Heart	☐ High cholesterol	☐ Kidneys
☐ Rashes or hives	☐ Very dry skin	☐ A lot of stomach aches
☐ Swollen joints	☐ Teeth	☐ Urine infections
☐ Vomiting	☐ Other _____	

Has your child ever been on a special diet? ☐ Yes ☐ No Describe _____

Do you think that your child weighs ☐ too little? ☐ just right? ☐ too much?

Does you child go for long periods of time without eating (i.e. skips meals)? ☐ Yes ☐ No

How many times a week does your child eat the following?

☐ Fried foods ☐ Fruit ☐ Junk food ☐ Milk ☐ Meat ☐ Vegetables

Has your child ever had sex? ☐ Yes ☐ No

If he/she has been sexually active, what birth control methods has he/she used?

☐ Condoms ☐ Withdrawal/pulling out ☐ Birth control pills ☐ Other _____

Would you like your child to speak to someone about birth control methods? ☐ Yes ☐ No

Has your child ever had a sexually transmitted disease (i.e. gonorrhea, chlamydia, syphilis, herpes or genital warts)? ☐ Yes ☐ No

Has your child ever had discharge from his penis/her vagina? ☐ Yes ☐ No

Are you concerned about your child getting HIV/AIDS? ☐ Yes ☐ No

Have you ever thought about having your child tested for HIV? ☐ Yes ☐ No

Would you like your child to receive information about HIV and safe sex? ☐ Yes ☐ No

IF YOUR CHILD IS FEMALE:

Has your daughter gotten her first period? ☐ Yes ☐ No What age? _____

Does it come about once a month? ☐ Yes ☐ No Date of last period: _____

Does your child have pain (cramps) with her period? ☐ Yes ☐ No

Has your daughter ever been pregnant or had a miscarriage or abortion? ☐ Yes ☐ No

Please check off any of the following that your child has tried:

☐ Alcohol (beer, wine, liquor) ☐ Cigarettes ☐ Cocaine (coke, crack)
☐ Heroin (smack) ☐ Marijuana (weed, reefer) ☐ Mescaline, LSD, MDMA (ecstasy, X)
☐ Pills (ups, downs) ☐ Other

Do you or your child think he/she has a substance abuse problem?	☐ Yes	☐ No
Does your child ever feel depressed (very down)?	☐ Yes	☐ No
What do you do to make your child feel better? _____		
Has your child ever thought about hurting or killing himself/herself?	☐ Yes	☐ No
If Yes, has he/she ever tried?	☐ Yes	☐ No
Has your child ever had counseling with a social worker or therapist?	☐ Yes	☐ No
Does your child have any problems at home?	☐ Yes	☐ No
Has anyone ever hit your child very hard or beat them?	☐ Yes	☐ No
Has anyone ever touched your child's body in a way that made him/her uncomfortable or without their consent?	☐ Yes	☐ No
Is there a gun kept in your home?	☐ Yes	☐ No
Has anyone mugged, attacked or injured your child?	☐ Yes	☐ No
Has your child ever witnessed any violence?	☐ Yes	☐ No

How many hours a day does your child watch TV? Weekdays _____ Weekends _____

_____ _____
Signature of Parent or Guardian Date

Mount Sinai Hospital *School Based Health Centers*

PATIENT NAME _____

DATE OF BIRTH ____/____/____

OFFICE USE ONLY

MRN/GENDER _____

AUTHORIZATIONS AND AGREEMENTS

The Mount Sinai Hospital School Based Health Centers provide services to all students who consent to receive services at **no cost** to the student or his/her family. In order for the program to continue, we do bill Medicaid and/or 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 Mount Sinai Hospital for any costs not covered by insurance. You **do not** have to pay for any services provided at The Mount Sinai School Based Health Centers. Signing this form **does not** change your insurance coverage.

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 Mount Sinai Hospital, to cover the cost of the care and treatment rendered to my child at The Mount Sinai Hospital School Based Health Centers ("SBHC").

2. **RELEASE OF INFORMATION**
   In the event my Insurer denies payment to The Mount Sinai Hospital 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 Mount Sinai Hospital 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 Mount Sinai Hospital for any service(s) furnished to him/her by SBHC providers.

4. **INSURANCE INFORMATION**
   I understand that The Mount Sinai Hospital will use various means to determine if my child has any insurance coverage including contacting other providers who have examined my child, 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 PATIENT _____ NAME OF PARENT/GUARDIAN _____

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

RELATIONSHIP TO PATIENT _____

Revised 8/21/2013

Mount
Sinai
Hospital

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other (explain):* _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

☐ Acknowledgement subsequently obtained, (see above).

Mount Sinai

SUMMARY - NOTICE OF PRIVACY PRACTICES

THIS SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES (NOTICE), REVISED AS OF SEPTEMBER 2013, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. MORE DETAILED INFORMATION IS CONTAINED IN OUR COMPLETE NOTICE. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Our Pledge to Protect your Privacy:
The Mount Sinai Hospital (MSH), including Mount Sinai Queens (MSQ); Icahn School of Medicine at Mount Sinai (ISM), including its Mount Sinai Doctors Faculty Practice (DFP), its owned off-site physician practices such as North Shore Medical Group (NSMG) and Mount Sinai Brooklyn Heights Medical Group (BHMG); and Mount Sinai Cares (collectively, "Mount Sinai" for purposes of this Notice) are required by law to protect the privacy of your health information. The privacy practices described will be followed by:

- Any healthcare professional who treats you at any Mount Sinai location;
- All employees, medical staff, trainees, students or volunteers at any Mount Sinai location;
- Any business associates of Mount Sinai and their subcontractors.

These privacy practices will be followed at sites of care associated with the Mount Sinai entities listed above. A list of current locations is included as Attachment E to the complete Notice and will be updated on our website (www.mssm.edu/HIPAA) as new locations are added or deleted.

Only to the extent necessary, we will use and share your medical information (PHI) to treat you, to conduct our business operations, to collect payment for the services we provide to you and to comply with applicable laws. (See notice pp 6-8)

- For fund raising, although you will always have the right to opt out of receiving these communications at anytime by emailing us at philanthropyoptout@mountsinai.org, calling us at 212-659-8500 or writing us at One Gustave L. Levy Place, New York, N. Y. 10029, Box 1049;
- To support our research mission as an academic medical center with approval of Mount Sinai's Privacy Board;
- For workers' compensation or similar programs;
- For required public health activities (e.g., reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health);
- For law enforcement in certain limited circumstances;
- To a coroner, medical examiner or funeral director as required by law;
- For organ procurement or transplantation, if you are a potential donor.

We will not use or disclose your information for any other purpose without your permission

You have the following rights to access and control your PHI: (See Notice pp. 2-5)

- To inspect and obtain a copy in either electronic or paper form of your PHI. We will produce the records in the specific electric format that you request if it is feasible to do so;
- To request restrictions on certain uses or disclosures of your PHI [For example, you may direct us not to share specific PHI with your insurance company if you plan to pay for a service personally without submitting a claim to your insurer. It is your responsibility to inform other providers who may receive copies of your record that they may not share this information with your insurance company;
- To request an accounting of Mount Sinai's disclosures of your PHI;
- To add an addendum or make an amendment to your medical record if you believe it is inaccurate or incomplete;
- To request that we communicate with you in a certain way or at a certain location;
- To receive a copy of the full version of our Notice;
- To be notified within 60 days if your PHI has been disclosed to or accessed by a person who was not authorized to receive the information.

For more information about this Summary or the full Notice, please contact our Privacy Office at 212-241-4669