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

Carliana 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.

<table>
<thead>
<tr>
<th>STUDENT INFORMATION</th>
<th>PARENT INFORMATION</th>
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<tbody>
<tr>
<td>Student Last Name:</td>
<td>Parent/ Legal Guardian:</td>
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<tr>
<td>Student First Name:</td>
<td>Last Name:</td>
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<tr>
<td>Date of Birth:</td>
<td>First Name:</td>
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<td></td>
<td>Home/Work Tel:</td>
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<tr>
<td>Student Address:</td>
<td>Cell Phone:</td>
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<td>Email:</td>
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<td>City</td>
<td>Parent/ Legal Guardian:</td>
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<td>State</td>
<td>Last Name:</td>
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<td>Student email:</td>
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<td>Email:</td>
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<tr>
<td>*Student Social Security Number:</td>
<td>Preferred Language of Parent/Guardian:</td>
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<tr>
<td>Sex: Male □ Female □</td>
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<tr>
<td>Ethnicity: Hispanic □ Black □ White □ American Indian □ Asian/Pacific Islander □ Other</td>
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<td>List the student's regular doctor, if they have one:</td>
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<tr>
<td>Name:</td>
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<td>Telephone:</td>
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<td>Address:</td>
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<tr>
<td>Indicate the Pharmacy where we can send prescriptions:</td>
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<tr>
<td>Pharmacy:</td>
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<tr>
<td>Pharmacy Address:</td>
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<tr>
<td>Pharmacy Tel:</td>
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<tr>
<td>*Indicates optional field: Used for Insurance purposes only</td>
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</tbody>
</table>

| 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 □ 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 ________________________________ Date ____________________________

Signature of Parent/Guardian

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 ________________________________ Date ____________________________

Signature of Parent/Guardian

Rev: 5.11.2018 PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT
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

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 (aka 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 (aka New York City Department of Education).

I consent to the release from the School-Based Health Center to the NYC Department of Education 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:

- Comprehensive Physical Exam (Form CH-205 or Equivalent such as sports exams, etc.)
- Vision and hearing screening results
- Immunizations (required/recommended)
- Tuberculosis Test results

- 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
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 __________________________

Revised 8/21/2013
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 (falling, 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 your 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

Revised 8/21/2013 2 of 3
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
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.

<table>
<thead>
<tr>
<th>NAME OF PATIENT</th>
<th>NAME OF PARENT/GUARDIAN</th>
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</thead>
<tbody>
<tr>
<td>SIGNSHATURE OF PARENT/GUARDIAN (or student if 18 years or older or otherwise permitted by law)</td>
<td>DATE</td>
</tr>
<tr>
<td>RELATIONSHIP TO PATIENT</td>
<td></td>
</tr>
</tbody>
</table>

Revised 8/21/2013
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).

MR-205 (Rev 5/04)
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 (BSMG); 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 philanthropypotou@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.