SYRACUSE COMMUNITY HEALTH

Delaware Elementary School	315-435-4452
Dr. Weeks School	315-435-4030
PSLA @ Fowler High School	315-435-4410
Franklin Magnet School	315-435-4102
Grant Middle School	315-435-4040
H. W. Smith School	315-435-6266
STEAM at Dr. King	315-435-4031
STEM at Blodgett School	315-435-6431

DearParent/Guardian

Did you know… your child can receive medical, dental, and behavioral health services while they are at school?

Syracuse Community Health Center, Inc. and the Syracuse City School District offer medical, dental and mental health services at your child's school through the *School Based Health Center* program.

A full range of primary health care services are available and include the following services:

- Physicals and check-ups (sports and work paper exams)
- Immunizations
- Dental services, cleanings, sealants, treatments and x-rays
- Mental health
- Treatment of acute and urgent sickness or minor injuries.

Best of all, these services will be provided with no out of pocket costs to you whether or not your child has health coverage. ***There is no need to change your primary care provider and you will not be penalized in ANY WAY for enrolling in the School Based Health Center program*****.**

A healthy child is key to learning and growing. We are making access to health care as convenient as possible. We strongly believe no child should experience academic difficulties because of lack of health care.

We encourage you to take advantage of this health care program for children. If your child is currently insured, no co-pay is required; we will bill your insurance carrier for the service. If your child is uninsured, we will help determine his/her eligibility for Child Health Plus. If you have insurance, it is important that you provide us with your child's insurance information at the time of enrollment so that we can bill appropriately for the services that are provided by the program.

Please call the telephone number above at your child's school to speak with the School Based Health Center Nurse Practitioner or go to our website at www.schcny.com/sbhc.

Before your child can participate, please complete the forms found within the enclosed packet and return them to your child's school. Thank you for your time. We look forward to serving your child's health care needs.

Sincerely,

Mark Hall
President & CEO
Syracuse Community Health Center

Sincerely,

Jaime Alicea
Superintendent of
Syracuse City School District

SYRACUSE COMMUNITY HEALTH

Name of School:_____

Office Use Only OSIS #: _____ 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: _____

Student's School: _____

Sex: ❑ Male ❑ Female Grade _____

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

Preferred Language: _____
Does your child have difficulty with English? ❑ Yes ❑ No

Student Address:_____
Apt:#_____ _____ _____ _____
City State Zip Code

PARENT/GUARDIAN INFORMATION

Mother's Name

Last:_____**First :**_____**DOB:**_____

Father's Name

Last :_____**First:**_____**DOB:**_____

Name of Legal Guardian, If Applicable
Last :_____**First:**_____**DOB:**_____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other:_____

Contact Information for parent or guardian
Home Tel:_____**Work Tel:**_____
Cell: _____
E-mail: _____

Additional Emergency Contact
Name:_____
Relationship to Student: _____
Home Tel:_____**Work Tel:** _____
Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

❑ No ❑ Yes: Medicaid ID #_____

Does your child have Child Health Plus?
❑ No ❑ Yes: CHP ID#_____

Which Medicaid/Child Health Plus Plan?
❑ UHC Community Plan ❑ Fidelis ❑ Molina ❑ Other_____
Does the student have health coverage through your employer or any other type of insurance? ❑ No ❑ Yes Health Plan: _____
Member ID/Policy Number: _____
Health Plan Phone Number: _____

Does your child have Dental Insurance?
❑ **No** ❑**Yes,** Dental Plan: _____
Member ID/Policy Number: _____
Health Plan Phone Number: _____
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

PROVIDER INFORMATION

Does the student have a regular doctor? ❑ No ❑ Yes:
Name: _____
Tel:_____
Address:_____

Does the student have a regular dentist? ❑ No ❑ Yes:
Name: _____
Tel:_____
Address:_____

Please indicate the pharmacy that is convenient for you, in order to electronically forward any needed prescriptions to the pharmacy.

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Tel. _____

BOX 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign box 1, 2, 3 to complete enrollment

I have read and understand the services provided at School-Based Health Centers and my signature provides consent for my child to receive services provided by the SCHC 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**

BOX 2. 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.

X_____ _____ _____
Signature of Parent/Guardian **PRINT PARENT/GUARDIAN NAME** **Date**
(or student if 18 years or older or otherwise permitted by law)

BOX 3: HEALTH E CONNECTIONS CONSENT CHOICE

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time.

☐ I GIVE CONSENT for SCHC to access ALL of my electronic health information through HealtheConnections to provide health care services

☐ I DENY CONSENT to access my electronic health information through HealtheConnections.

X_____ _____ _____
Signature of Parent/Guardian **PRINT PARENT/GUARDIAN NAME** **Date**

SYRACUSE COMMUNITY HEALTH

Name of School:_____

CONSENT FOR SCHOOL BASED HEALTH CENTER SERVICES

I give my consent for my child to receive health/dental/mental health care services by the staff of the SCHC School Based Health Center program, including:

- Complete physical checkups (mandated physicals, sports physicals, working papers)
- First aid and assessment of acute illness, prescriptions when necessary
- Lab tests when necessary to detect illness or infection
- Hearing, vision, scoliosis and blood pressure screening
- Immunizations and allergy injections (by order of an allergist)
- Dental screening, fluoride treatments, Prophylaxis (cleanings), sealants, x-rays, education and counseling
- Care for skin problems
- Mental Health counseling
- Health education, nutrition and weight counseling
- Counseling for school and personal problems
- Referral to outside agencies (specialists, counselors, etc.) for services not provided at the School Based Health Center

Additional services offered for teens include**:**

- Alcohol and drug abuse and prevention counseling, family counseling
- Counseling regarding puberty, peer pressure, communication and responsible decision making (in accordance with guidelines)
- Counseling options of pregnancy prevention, including abstinence and contraception, when necessary or at request of parent or guardian

I authorize the release of necessary medical/dental/mental health information to my designated insurance carrier for claims, and direct that any insurance payments be sent to Syracuse Community Health Center, Inc.

If my child's Primary Care Provider (PCP)/Dentist are not affiliated with SCHC, I authorize the release of medical information to and from my child's PCP and specialty health care practices unless otherwise specified. Health information may be shared with the Syracuse City School District nurse and affiliated staff where necessary and pursuant to a demonstrated need to share information as allowed by New York State Law.

I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment of or advice regarding alcohol/drug abuse, mental health counseling, sexually transmitted diseases, pregnancy or contraception. The staff of SCHC's School Based Health Center programs considers parental involvement very important. Accordingly, the staff will encourage every student to involve his or her parents or guardians in all counseling and medical/dental care decisions.

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

By signing this Consent Form, you give us permission to use and disclose protected health information about you/your child for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical/dental or mental health, to provision of healthcare services to you, and to the collection of payment for providing medical/dental/counseling services to you/your child.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you/your child. You have the right to receive a copy before signing this Consent Form. By signing this consent form, you acknowledge you have received/been made aware of our *Notice of Privacy Practices.*

You have the right to request that we restrict how protected health information about you/your child is used or disclosed for treatment, payment, or healthcare operations. *We are not required to agree to any restrictions, but if we do, we are bound by our agreement.* If you wish to make a restriction, please request a copy of our Form to Request Restriction.

If you do not sign this Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you/your child require emergency treatment or we are required by law to treat you/your child. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

I understand that photographs, videotapes, digital, or other images may be recorded to document my child's care, and I consent to this. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

HEALTH E CONNECTIONS CONSENT INFORMATION

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Syracuse Community Health Center** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more and for full details of the consent form, visit http://healtheconnections.org/who-we-serve/patients/ or request a form from your school's Nurse Practitioner. My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

BASIC HEALTH HISTORY

CHILD'S NAME	DOB (mm/dd/yyyy)	GRADE	SCHOOL

Dear Parent/Guardian: Your child's health is important to us. To better understand your child's healthcare needs for ongoing care and in case of emergency, please answer the following questions.

Allergies:	**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 the child have an Epi-pen?		
Has your child had any serious or chronic health problems?	**No**	**Yes**
Asthma		
Attention Deficit Disorder		
Depression or Anxiety *(circle one or both, if yes)*		
History of a Heart Murmur		
Seizure Disorder		
Sickle Cell Anemia		
Other:		
Does your child take any medications regularly? **If yes, please specify name(s) and Dose(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.____**		

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? Who? _____**		
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 spices) imported from Haiti, Mexico, Pakistan, the Dominican Republic, or Bangladesh?		

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

With whom does the child live most of the time? Circle all that apply:				
Both parents	Mother only	Father Only	Stepmother	Stepfather
Grandparent/ Other Adult Relative:	Sisters and Brothers: Ages_____	Other children: Ages_____	Foster Parent	Other Guardian
In the past year, have there been any changes in your family? Circle all that apply:				
Marriage	Separation	Divorce	Loss of Job	Move to a new neighborhood
New school	Births	Serious Illness	Deaths	Other

Please use blank space below to tell us any concerns you have about your child.

We will always inform you if your child is very ill and needs to leave school or seek urgent care. *Please always inform us if your contact information ever changes. We will make our best effort to inform you, either by calling or by sending home a letter to you with your child*

Today's Date (mm/dd/yy)	*Name*	*Signature*	*Relationship to child*

(Check if child is in foster care □)