Jordan Health at Padilla is a School Based Health Center offered at The Franklin Campus. It is available to all students that attend the Campus. Attached is an enrollment form and family demographic data sheet to be complete by a **parent** or **legal guardian** and returned to school with your child. If you are the **legal guardian** please send in a copy of the legal paperwork signed by a judge along with completed forms. We will need these before we can provide services to your child.

We have a Licensed Nurse Practitioner on site that can attend to the medical needs of your child, as well as collaborate care with the students Primary Care Provider. If the student does not have a Primary Care Provider, the Licensed Nurse Practitioner at the SBHC can serve as the students Primary Care Provider. In the event the Provider at the SBHC is not available, Anthony L. Jordan has several locations where the student's medical needs can be met. If there is an emergency please call (585)324-3726. ***All services are offered at no out of pocket cost to you***. We do bill insurance and if your child is uninsured and you are interested in signing up for insurance, **please contact us at (585)324-3726.**

Services Offered:

Physicals
Sick Child Visits
Medication prescriptions and refills
(Restrictions apply)
Immunizations
Family planning services
Mental Health Counseling (by referral)

Please make sure forms are completely filled out and signed

Completed forms can be returned by **mail, fax** or **email** to:

By Mail
Padilla Campus
Room 241
950 Norton Street
Rochester, New York 14621
(585)324-3726

Faxed
(585) 336-5525

Email
FranklinSBHC@jordanhealth.org

950 Norton St. Rochester, NY 14621 - 585-324-3726

School based Health Services

I consent for my child to receive health care services provided by the Jordan Health staff as part of the School Based Health Clinic (SBHC) 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 students will be encouraged to involve their parents or guardians in counseling and medical care decisions. SBHC services may include, but are not limited to:

1. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers and new entrants.
2. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
3. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
4. Mental health services including evaluation, diagnosis and counseling referrals.
5. Reproductive health services, including contraception (birth control pills etc.) testing for pregnancy, STD screening and treatment, HIV testing, PAP smears and referrals for abnormal results as age appropriate.
6. Nutrition and weight counseling
7. Health education and counseling for the prevention of risk-taking behavior 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.
8. Referrals for service not provided at the School based health Center.

Authorization for Release of Behavioral and/or Medical Information

My signature on the reverse side of this document authorizes the exchange of information between the SBHC and the Rochester City School District's School Nurse Office, and the teachers, administrators, counselors, and social workers at my student's school. I further authorize the exchange of medical information with other medical providers who have examined the student named on this form and our insurance provider. I understand that only information required by state law and/or information to protect the health and safety of the student will be disclosed to the Nurse's Office and only information needed to provide continuity of care will be exchanged with other health care offices.

Information required by RCSD may include but is not limited to:	**Information to Protect Health and Safety may include but is not limited to:**	**Information to provide continuity of medical care may include but is not limited to:**
• **New entrant exams** • **Immunizations** • **Vision & hearing screening** • **Tuberculin Test results**	• **Conditions which may require emergency medical treatment** • **Conditions which limit a student's ability to perform at full potential** • **Diagnosis of certain communicable diseases (NOT including HIV infections/STI and other confidential services protected by law)**	• **Physical exams and immunizations** • **Illnesses including medications prescribed and results of any diagnostic testing** • **Results of monitoring done related to any acute or chronic health problems** • **Referrals made to outside specialists**

***I understand that:**

- I may cancel this authorization at any time by submitting a written request to the SBHC address above, except where a disclosure already made in reliance on my prior authorization
- If the person or facility receiving disclosed private health information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- If the authorized information is protected by Federal Confidentiality Rules related to substance abuse, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV related information requires additional authorization

Release of information is authorized **FROM:** The date this form is signed **TO**: The date student is no longer enrolled in SBHC

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS DOCUMENT

Student Information: **School**:_____ **Grade**:_____

Last Name, First Name: _____ Date of Birth_____

Student Social Security Number_____/_____/_____ Male____ Female____ Transgender____

Ethnicity: Latino____ Black____ White____ Other_____ Hispanic: Yes: ____ No: ____

Student Lives With: Mother_____ Father_____ Other_____

Address:_____

Mothers Name:_____

Phone Number:_____ **Work**:_____

Fathers Name:_____

Phone Number:_____ **Work**:_____

Legal Guardian Information if different from parent:

Legal Guardian Name: _____

Address_____

Phone Number: _____ Work Number: _____

Insurance Information:

Insurance Company Name: _____

Insurance ID Number: _____ Medicaid CIN #: _____

Date of Last Complete Physical Examination: _____

Primary Doctor Information:

Doctor's Name: _____ Phone Number: _____

Address: _____

ALLERGIES: _____

PHARMACY: _____ **Address**_____

Phone _____

I have read and understand the services listed (SCHOOL BASED HEALTH SERVICES) and my signature below documents consent for my child to receive services provided by the SBHC at Padilla educational campus.

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 endangered. Parental consent is not required for students who are 18 years or older or for students who are parents or otherwise legally able to sign on their own behalf.

My signature indicates I have received a copy of the Notice of Privacy practices.

I have read and understand the release of health information on the reverse side of this form and my signature indicates my consent to release of medical information as specified. This includes release to other doctors, and health insurance companies for billing as needed.

Parent/Legal Guardian Signature: _____ **Date:** _____

Approved for: FP/MH_____ALL_____ Practice Manager_____

Padilla School Based Health Center Release of Information

I _____, the parent or legal guardian of _____
(Parent/legal guardians name) (Student's Name)

whose date of birth is _____, give my permission for _____
(Doctor's Name)

to share the all of the student's health records with Jordan Health at Padilla School Based Health Center. Please include the most recent physical examination and immunization records, and the following information if initialed:

_____ Mental Health (Initials) _____ HIV/AIDS (Initials) _____ Alcohol/Drug treatment (Initials)

I am requesting these health records so Jordan Health can provide school based health care services to the student listed above.

My permission to share is valid for as long as the student is enrolled in the Jordan Health at Franklin School Based Health Clinic.

I understand that:

- I may cancel my permission at any time. I can do so by writing to: Practice Manager, Jordan Health at Franklin, 82 Holland Street, Rochester, NY 14605. If the health record has already been shared it may be too late to cancel my permission.
- Jordan Health at Franklin may share the health record as allowed by State and Federal law.
- If I have given permission to share mental health, HIV/AIDS, or alcohol/drug treatment records, Jordan Health at Franklin may not share that information without my permission unless permitted by State or Federal law.
- Giving my permission to share the student's health records is voluntary and that his or her treatment, payment or benefit eligibility is not conditional upon my permission. However, I understand that the student may be denied treatment is some cases if I do not sign this form.

Parent/Guardian Signature:_____ Date: _____
Patient Signature:_____ Date: _____

Parent/Guardian Name: _____
Patient Name: _____

Describe how this person has legal authority to sign this form: _____
_____

I have given the parent/guardian a copy of this signed form: _____
Staff Member Signature and Date

To the practice receiving this authorization to release information: Please fax or mail to:

Jordan Health at Franklin
322 Lake Avenue
Rochester, NY 14608
Fax: 585-336-5525

Questions – please call 585-324-3726