SCHOOL-BASED HEALTH CENTER SERVICES

EAST HIGH SCHOOL
1801 East Main Rochester, NY 14609
585-288-1390

OR

FREDERICK DOUGLASS CAMPUS
940 Fernwood Park, Rochester, NY 14609
585- 324-9210

I consent for my child to receive health care services provided by the Strong Health Medical Staff as part of the ***School-Based Health Center*** 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. ***School-Based Health Center*** 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.
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, counseling, and referrals.
6. Reproductive health care services, including contraception, (birth control pills, Depo (the shot) etc, testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. Nutrition and weight counseling.
8. 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.
9. Referrals for service not provided at the school based health center.
10. Care is available 24 hours a day, seven days a week. Call 585-435-2332 for After Hours care.

STRONG HEALTH

Authorization for Release of Behavioral Health and/or Medical Information

My signature on the reverse side of this document authorizes the exchange of medical information between the ***School-Based Health Center*** and the Rochester City School District's School Nurse Office. 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:

- New Entrant exams
- Immunizations
- Vision and Hearing Screening Results
- Tuberculin Test Results

Information to Protect Health and Safety may include but is not limited to:

- Conditions which may require emergency medical treatment
- Conditions which limit a student's daily activity
- Diagnosis of certain communicable diseases (**not** including HIV infection/STI and other confidential services protected by law).

Information to provide continuity of medical care may include but is not limited to:

- Physical exams and immunizations
- Treatment relating to acute or chronic 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 ***School-Based Health Center*** address above, except where a disclosure has already been 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.
- If the medical record information is not sent to another care provider, there may be a charge for the requested records.

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 ***School-Based Health Center***

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS DOCUMENT

STRONG HEALTH School-Based Health Centers

Office Use Only
MRN: **NPV:**

SCHOOL-BASED HEALTH CENTER PARENTAL CONSENT FORM

STUDENT INFORMATION

Student's Last Name:_____

Student's First name:_____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number_____

Sex: [1]❑ Male [2]❑ Female Grade_____

Ethnicity: [4]❑ Latino [2]❑ Black [1]❑ White [6]❑ Other

Student Address:_____

_____

_____
Zip Code

Who is the student's regular doctor?

Name:_____

Telephone:_____

Address:_____

PARENT/GUARDIAN INFORMATION

Mother

Last Name:_____ **First Name:**_____

Father

Last Name:_____ **First Name:**_____

Legal Guardian, If Applicable:

Last Name:_____ **First Name:**_____

Relationship of legal guardian to student:

[1]❑ Grandparent [2]❑ Aunt or Uncle [3]❑ Other:_____

Contact Information for parent or guardian.

Home Tel:_____ **Work Tel:**_____

Beeper/Cell:_____

Additional Emergency Contact

Name:_____ Relationship to student_____

Home tel:_____ Work tel:_____

Beeper/Cell:_____

INSURANCE INFORMATION

Does your child have Medicaid:

❑ No ❑ Yes: Medicaid ID #_____

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

Does your child have other insurance?

❑ No ❑ Yes: Name:_____
ID # _____

If your child does not have insurance would you like assistance in obtaining insurance? ❑ No ❑ Yes

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature below documents consent for my child to receive services provided by the School-Based Health Center.

NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, pre-natal 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 otherwise legally able to sign on their own behalf . 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)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

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.

X_____

Signature of Parent/Guardian *(or student if otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS DOCUMENT