# SCHOOL-BASED HEALTH CENTER
## PARENT/GUARDIAN CONSENT FORM


**East Health Clinic** - 1801 East Main St. **585-288–1390**
**585-288-1392-fax** **585-435-2332- afterhours**

**Frederick Douglass Clinic** -940 Fernwood Park **585-324-9210**
**585-324-9211-fax** **585-435-2332- afterhours**

| STUDENT INFORMATION | PARENT/GUARDIAN INFORMATION |
|---|---|
| **Student's** Name:_____<br>Address:_____<br><br>**Student Cell #**_____<br>*Is it ok to text to this cell?* ❑No ❑ **Date of Birth:** ____/____/_____<br><br>**Student's Social Security Number**_____<br>**Gender** _____ **Current Grade** _____<br>**Ethnicity**: ❑ Latino ❑ Black ❑ White ❑ Other<br>**Has the student received mental health services?** ❑No ❑Yes:<br>Name/Site: _____<br>Telephone: _____ | **Guardian's** Name: _____<br>Relationship to student _____<br>Address:_____<br>**Contact Number for parent(s) or guardian:**<br>Home _____ Work _____<br>Cell:_____<br>**Additional Emergency Contact:**<br>Name:_____<br>Relationship to student: _____<br>Home: _____ Work: _____<br>Cell:_____ |

**STUDENT MEDICAL HISTORY**

Primary Care Provider **?** _____ Mental Health Provider: _____

Allergies? _____ Medications? _____

Health problems? _____ Other concerns? _____

**INSURANCE INFORMATION**

**Does your child have Medicaid or CHP?**
❑ No ❑ Yes: Medicaid ID #_____
**If your child does not have insurance would you like assistance in obtaining insurance? ❑ No ❑ Yes**

**Does your child have other insurance?**
❑ No ❑ Yes: Name:_____
ID # _____

**PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES**

I consent for my child to receive health care services provided by the University of Rochester 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. 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, counseling, and referrals.
5. 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.
6. Nutrition and weight counseling.
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.
8. Referrals for service not provided at the school based health center.
9. Refractive vision screening for prescriptive eyewear.
10. Care is available 24 hours a day, seven days a week. **Call 585-435-2332 for After Hours care.**

I have read and understand the services listed above 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**

**PLEASE SEE OTHER SIDE. TURN OVER. →→→→**

East Health Clinic
1801 E Main St.
Rochester, NY 14609
585-288-1390 office
585-288-1392 fax

Frederick Douglass Health Center
940 Fernwood Park
Rochester, NY 14609
585-324-9210 office
585-324-9211 fax

**After hours care:**

**585-435-2332**

# Authorization for Release/Disclosure of Medical Information

Patient/student name: _____

Date of Birth:_____

My signature authorizes the exchange of medical information between the School-Based Health Center (SBHC) and the Rochester City School District's School Nurse Office in order for my child to receive health care services in the SBHC . I also consent to allow the SBHC access to my child's academic schedule to facilitate appointment scheduling and further consent to the exchange of information concerning appointment dates and times with my child's teachers. No medical information will be released to teachers by SBHC staff. 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<br>➢ Immunizations<br>➢ Vision and Hearing Screening Results<br>➢ Tuberculin Test Results | ➢ Conditions which may require emergency medical treatment<br>➢ Conditions which limit a student's daily activity<br>➢ Diagnosis of certain communicable diseases (**not** including HIV infection/STI and other confidential services protected by law). | ➢ Physical exams and immunizations<br>➢ Treatment relating to acute or chronic illnesses including medications prescribed and results of any diagnostic testing.<br>➢ Results of monitoring done related to any acute or chronic health problems.<br>➢ 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.
- Access to School-Based Health Center services is not conditioned on this authorization.

❖ **Time Period During Which Release of Information is Authorized:**

**Valid From:** Date the form is signed **To:** Date that student is **no** longer enrolled in the **School-Based Health Center**

**X**_____ _____

**Signature of Parent/Guardian** (or student if 18 years or older or otherwise permitted by law) **Date**

**PLEASE SEE OTHER SIDE. TURN OVER. →→→→**