# NYC Department of Education School Health Program
# School Parental Consent Form (Grades 9-12)



*High School for Fashion Industries*
*School-Based Health Center 212-206-2910*
*225 West 24th St, 3rd Floor*
*New York, NY 10011*

***Any/all of your information will be used only by Health Center staff and kept completely confidential***

***Office Use Only***

## STUDENT INFORMATION

**Student's Last Name**: _____
**Student's First Name**: _____
**Date of Birth**: _____/_____/_____
*Month Day Year*
**Student's Social Security Number:** _____
**Sex**: ❑ Male ❑ Female Grade _____
**Ethnicity**: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____

**Student Address**: _____
_____
_____ _____ _____
*City State 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
❑ Grandparent ❑ Aunt or Uncle ❑ 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

****Please fill out this section *as completely as possible*****

**Does your child have Medicaid?**
❑ No ❑ Yes: Medicaid ID # _____

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

**Which Plan?**
❑ Affinity ❑ NYP Community Health Plan
❑ Neighborhood ❑ Amerigroup
❑ HIP ❑ Health Plus
❑ Other: _____

**Does your child have other insurance?**
❑ No ❑ Yes: Name: _____
Coverage Number: _____

**If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a NY State approved low-income health insurance plan?**
❑ No ❑ Yes

## PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

****Please *sign and date* BOTH lines****

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 **HIGH SCHOOL FOR FASHION INDUSTRIES** 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)* **Date**

## 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** *(or student if 18 years or older or otherwise permitted by law)* **Date**

**PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT**

THE INSTITUTE FOR FAMILY HEALTH

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*High School for Fashion Industries School Based Health Center*
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## SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of **HIGH SCHOOL FOR FASHION INDUSTRIES SCHOOL BASED HEALTH CENTER** 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. Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot) among other methods], testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
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. 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'S 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. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Board of Education of the City of New York (a/k/a 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 **HIGH SCHOOL FOR FASHION INDUSTRIES** 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 (a/k/a New York City Department of Education).

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

**Information Required by Law or Chancellor's Regulation:**
- New Entrant Exam (Form 211S)
- Immunizations
- Vision and hearing screening results
- Tuberculin test results

**Information to Protect Health and Safety**:
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Health insurance coverage

**My signature on page 1 of this form also gives my consent to** HIGH SCHOOL FOR FASHION INDUSTRIES SCHOOL BASED HEALTH CENTER **to contact other providers that have examined my child and to obtain insurance information.**

**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

**PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT**