

DEAR PARENT:

PLEASE FILL OUT THE FOLLOWING FORMS COMPLETELY. WE PREFER THAT YOU ACCOMPANY YOUR CHILD TO THEIR EXAM, BUT WILL SEE THEM WITHOUT YOU BEING PRESENT IF:

- **THE FORMS ARE ALL FILLED OUT BEFORE THE APPOINTMENT**
- **THE CHILD BRINGS HIS/HER IMMUNIZATION CARD WITH THEM**
- **WE CAN REACH YOU BY PHONE DURING THE EXAM**

YOUR DAYTIME PHONE NUMBER IS: _____

QUERIDOS PADRES:

POR FAVOR DE LLENAR LA SIGUIENTES FORMAS COMPLETAMENTE. PREFERIMOS QUE USTED ACOMPAÑE SU NIÑO/A A SU EXAMEN, PERO LOS VEREMOS SIN USTED ESTAR PRESENTE SI:

- **LOS FORMULARIOS ESTÁN TODOS LLENOS ANTES DE LA CITA**
- **EL NIÑO/A TRAE SU TARJETA DE VACUNAS**
- **PODEMOS ALCANZARLE POR TELÉFONO DURANTE EL EXAMEN**

SU NÚMERO DE TELÉFONO DURANTE EL DÍA ES:

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**The Mount Sinai Hospital School Based Health Center
at PS 38/Dream Charter School, PS 83/PS 182, PS 108, and TAG/MS 372/MS 381
Parental Consent Form (Grades PK-8)**

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of Mount Sinai Hospital 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. 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.
7. Dental examinations including: diagnosis, treatment, and sealants where available.
8. Referrals for service not provided at the school-based health center.
9. 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 Mount Sinai Hospital 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 CH-205)
- 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 Mount Sinai Hospital 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



PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____

OFFICE USE ONLY

MRN/GENDER _____

MEDICAL HISTORY FORM (PRE-K TO 5TH GRADE)

PAST MEDICAL HISTORY

In what hospital was your child born? _____ Birth Weight _____

Did your baby go home with you? Yes No

Has your child ever had an operation? Yes No

Has your child had to stay in the hospital overnight? Yes No

If so, for what condition? _____

What hospital(s)? _____ Date(s) _____

Has your child ever had a serious injury? Yes No

Has your child had any of the following conditions?

Allergies Anemia Asthma Bleeding problem

Chicken Pox Diabetes Eczema Heart condition

Kidney problem Measles Pneumonia Seizures

Tuberculosis Other (specify) _____

Do they have any allergies? (medication, food, etc.)? Yes No

If Yes, list allergies: _____

Has your child seen the dentist in the past year? Yes No

Are your child's immunizations up to date? Yes No

When was their last tuberculosis (PPD) test? _____

When was their last tetanus shot? _____

Has your child left the U.S. in the past five years? Yes No

If Yes, where did they go? _____

FAMILY HISTORY

Who does your child live with?

mother stepmother grandmother aunt(s) sister(s) niece foster parent

father stepfather grandfather uncle(s) brother(s) nephew cousin(s)

List brothers or sisters whom they do not live with: _____

Do you live in a(n) Apartment? Private house? Shelter/Hotel?

Do any family members (including grandparents, aunts, uncles, cousins, etc.) have any of the following conditions?

Allergy/Hay fever Alcohol abuse Anemia/Bleeding issues Asthma

Cancer Diabetes Drug use Emotional problems

Heart problems High blood pressure High cholesterol HIV/AIDS

Kidney problems Learning problems Obesity Seizures

Stroke Tuberculosis (TB) Other _____

SCHOOL HISTORY

What school does your child attend? _____ Grade? _____

Has he/she ever been left back? Yes No Is he/she in special ed? Yes No

Does he/she have any problems with school work (failing, poor attendance)? _____

Does he/she have any behavioral problems or concerns? _____

What plans does he/she have for the future? _____

PERSONAL HEALTH

Has your child have (or ever had) a problem with any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Trouble breathing |
| <input type="checkbox"/> Broken bones (fractures) | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizzy or fainting spells | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Rashes or hives | <input type="checkbox"/> Very dry skin | <input type="checkbox"/> A lot of stomach aches |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Teeth | <input type="checkbox"/> Urine infections |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Other _____ | |

Has your child ever been on a special diet? Yes No Describe _____

Do you think that your child weighs too little? just right? too much?

Does your child go for long periods of time without eating (i.e. skips meals)? Yes No

How many times a week does your child eat the following?

Fried foods Fruit Junk food Milk Meat Vegetables

Does your child ever feel depressed (very down)? Yes No

What do you do to make your child feel better? _____

Has your child ever thought about hurting or killing himself/herself? Yes No

If Yes, has he/she ever tried? Yes No

Has your child ever had counseling with a social worker or therapist? Yes No

Does your child have any problems at home? Yes No

Has anyone ever hit your child very hard or beat them? Yes No

Has anyone ever touched your child's body in a way that made him/her uncomfortable or without their consent? Yes No

Is there a gun kept in your home? Yes No

Has anyone mugged, attacked or injured your child? Yes No

Has your child ever witnessed any violence? Yes No

How many hours a day does your child watch TV? Weekdays _____ Weekends _____

Signature Parent or Guardian

Date



The Mount Sinai Hospital
School Based Health Centers

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____

OFFICE USE ONLY

MRN/GENDER _____

AUTHORIZATIONS AND AGREEMENTS

The Mount Sinai Hospital School Based Health Centers provide services to all students who consent to receive services at **no cost** to the student or his/her family. In order for the program to continue, we do bill Medicaid and/or other insurance carriers to receive payments. You may receive a notice called an Explanation of Benefits (EOB) from your insurance carrier with information regarding the services billed and the payments that have been approved. You **will not** receive a bill from The Mount Sinai Hospital for any costs not covered by insurance. You **do not** have to pay for any services provided at The Mount Sinai School Based Health Centers. Signing this form **does not** change your insurance coverage.

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT

I authorize payment of medical benefits to which the patient named below ("my child") is entitled directly to The Mount Sinai Hospital, to cover the cost of the care and treatment rendered to my child at The Mount Sinai Hospital School Based Health Centers ("SBHC").

2. RELEASE OF INFORMATION

In the event my Insurer denies payment to The Mount Sinai Hospital for services rendered to my child, I hereby give my consent to have an authorized representative of the Hospital contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to my child by the SBHCs, which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize The Mount Sinai Hospital School Based Health Centers, my treating provider and their respective designees to use and disclose my child's health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying) to insurers and guarantors if needed for payment of SBHC and professional charges.

3. MEDICAID AND/OR OTHER INSURANCE CARRIER – RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I certify that the insurance information given by me regarding my child is correct. I authorize any holder of medical or other information about my child to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which my child has coverage any information needed for this or a related claim. I request that payment of authorized benefits be made on my child's behalf to The Mount Sinai Hospital for any service(s) furnished to him/her by SBHC providers.

4. INSURANCE INFORMATION

I understand that The Mount Sinai Hospital will use various means to determine if my child has any insurance coverage including contacting other providers who have examined my child, the Electronic Medicaid Eligibility Verification System or other holders of information about my child. I understand that these other sources of information will be used to confirm any insurance information I provided on the medical consent/registration form.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

NAME OF PATIENT

NAME OF PARENT/GUARDIAN

SIGNATURE OF PARENT/GUARDIAN (or student if 18 years or older or otherwise permitted by law)

DATE

RELATIONSHIP TO PATIENT



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES (NOPP)**

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Patient Name

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- The patient refused to sign despite good faith efforts*
- The patient was unaccompanied and not alert and oriented*
- The patient was unaccompanied and needed emergency care*
- Other (explain):* _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

- Acknowledgement subsequently obtained, (see above).



SUMMARY – NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE HAVE ALSO MADE AVAILABLE TO YOU A FULL VERSION OF THE NOTICE.

Our Pledge to Protect your Privacy:

The Mount Sinai Hospital, Mount Sinai School of Medicine and Mount Sinai Diagnostic and Treatment Center (“Mount Sinai”) are committed to protecting the privacy of your medical information. So that we can best meet your needs, we share your medical information with all the healthcare providers involved in your care. Only to the extent necessary, we also use and share your information to conduct our business operation, to collect payment for the services we provide to you and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

You have the following rights to access and control your health information: (See Notice pp. 3-6)

- To inspect and obtain a copy of your medical and billing records, subject to some special requirements for substance and alcohol abuse, genetic, mental health and HIV-related data;
- To request restrictions on certain uses or disclosures of your medical information;
- To request an accounting of Mount Sinai’s disclosures of your medical information;
- To add an addendum to your medical record;
- To request that we communicate with you in a certain way or at a certain location;
- To receive a copy of the full version of our Notice of Privacy Practices.

Examples of how we may use and disclose your health information: (See Notice pp. 6-10)

- To provide you with medical treatment and services;
- To bill and receive payment for the treatment and services you receive;
- For functions necessary to run Mount Sinai and to assure that our patients receive quality care;
- To provide only demographic information to our development office for purposes of fundraising for Mount Sinai;
- To support our research mission as an academic medical center with approval of Mount Sinai’s Privacy Board;
- For workers’ compensation or similar programs;
- For required public health activities (e.g., reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health);
- For law enforcement in certain limited circumstances;
- To a coroner, medical examiner or funeral director as required by law;
- For organ procurement or transplantation, if you are a potential donor.

For further information about the full Notice, please contact

*Mount Sinai Hospital and Diagnostic and Treatment Center Privacy Officer
at (212) 241-4669*

Mount Sinai School of Medicine FPA Patient Rights Coordinator (212) 241-7715

Mount Sinai Hospital Queens Privacy Officer at (718) 267-4220

Northshore Medical Group Privacy Officer at (631)367-5125