DEAR PARENT:

PLEASE FILL OUT THE FOLLOWING FORMS COMPLETELY. WE SUGGEST THAT YOU FILL THEM OUT WITH YOUR TEEN TO ANSWER ALL QUESTIONS. WE PREFER THAT YOU ACCOMPANY YOUR TEEN TO THEIR EXAM, BUT WILL SEE THEM WITHOUT YOU BEING PRESENT IF:

- **THE FORMS ARE ALL FILLED OUT BEFORE THE APPOINTMENT**
- **THE TEEN 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. SUGERIMOS QUE USTED LO LLENE CON SU ADOLESCENTE PARA CONTESTAR TODAS LAS PREGUNTAS. PREFERIMOS QUE USTED ACOMPAÑE SU ADOLESCENTE A SU EXAMEN, PERO LOS VEREMOS SIN USTED ESTAR PRESENTE SI:

- **LOS FORMULARIOS ESTÁN TODOS LLENOS ANTES DE LA CITA**
- **EL ADOLESCENTE 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 Esperanza Preparatory Academy (MS372) Parental Consent Form (Grades 9-12)

Office Use Only: **MRN** _____

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____

Student's Social Security Number: _____

Gender: [1]❑ Male [2]❑ Female **Grade:** _____

Ethnicity: [1]❑ Hispanic [3]❑ White [5]❑ American Indian
[2]❑ Black [4]❑ Asian / PI [6]❑ Other _____

If Hispanic: [1]❑ Dominican [3]❑ Mexican
[2]❑ Puerto Rican [4]❑ Other _____

Student's Address: _____

City: _____ **Zip Code:** _____

Who is the student's regular doctor?

Name: _____

Phone: _____

Address: _____

When was the last time your child had a complete medical examination?

Month _____ Year _____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____ First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, if applicable:

Last Name: _____ First Name: _____

Relationship to Student: _____

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 Health Insurance? ❑ No ❑ Yes

If Yes, which insurance does your child have? *(Please check one)*

❑ Medicaid ❑ Medicaid Managed Care ❑ Child Health Plus

ID Number: _____

Which plan? ❑ Affinity ❑ Healthfirst ❑ Health Plus ❑ HIP
❑ Metroplus ❑ Neighborhood ❑ NYS Catholic
❑ Other _____

Does your child have any other type of insurance? ❑ No ❑ Yes

If Yes, Plan Name _____

Coverage Number _____

Name of Insured Parent/Guardian: _____

Date of Birth of Insured Parent/Guardian: _____

Relationship to Student: _____

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 provides consent for my child to receive services provided by The Mount Sinai Hospital 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**

The Mount Sinai Hospital School Based Health Center
at Esperanza Preparatory Academy (MS372)
Parental Consent Form (Grades 9-12)

SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of The 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. 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 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
- Enrollment in School-Based Health Center

My signature on page 1 of this form also gives my consent to The 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

The Mount Sinai Hospital
School Based Health Centers

PATIENT NAME _____

DATE OF BIRTH ____/____/____

OFFICE USE ONLY

MRN/GENDER _____

MEDICAL HISTORY FORM (6TH – 9TH 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?

☐ Acne	☐ Bleeding	☐ Trouble breathing
☐ Broken bones (fractures)	☐ Chest pains	☐ Constipation
☐ Diarrhea	☐ Dizzy or fainting spells	☐ Eyes
☐ Wear glasses	☐ Frequent headaches	☐ High blood pressure
☐ Heart	☐ High cholesterol	☐ Kidneys
☐ Rashes or hives	☐ Very dry skin	☐ A lot of stomach aches
☐ Swollen joints	☐ Teeth	☐ Urine infections
☐ Vomiting	☐ 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 you 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

Has your child ever had sex? ☐ Yes ☐ No

If he/she has been sexually active, what birth control methods has he/she used?

☐ Condoms ☐ Withdrawal/pulling out ☐ Birth control pills ☐ Other _____

Would you like your child to speak to someone about birth control methods? ☐ Yes ☐ No

Has your child ever had a sexually transmitted disease (i.e. gonorrhea, chlamydia, syphilis, herpes or genital warts)? ☐ Yes ☐ No

Has your child ever had discharge from his penis/her vagina? ☐ Yes ☐ No

Are you concerned about your child getting HIV/AIDS? ☐ Yes ☐ No

Have you ever thought about having your child tested for HIV? ☐ Yes ☐ No

Would you like your child to receive information about HIV and safe sex? ☐ Yes ☐ No

IF YOUR CHILD IS FEMALE:

Has your daughter gotten her first period? ☐ Yes ☐ No What age? _____

Does it come about once a month? ☐ Yes ☐ No Date of last period: _____

Does your child have pain (cramps) with her period? ☐ Yes ☐ No

Has your daughter ever been pregnant or had a miscarriage or abortion? ☐ Yes ☐ No

Please check off any of the following that your child has tried:

☐ Alcohol (beer, wine, liquor) ☐ Cigarettes ☐ Cocaine (coke, crack)
☐ Heroin (smack) ☐ Marijuana (weed, reefer) ☐ Mescaline, LSD, MDMA (ecstasy, X)
☐ Pills (ups, downs) ☐ Other

Do you or your child think he/she has a substance abuse problem? ☐ Yes ☐ No

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 of Parent or Guardian Date

THIS PAGE IS INTENTIONALLY BLANK

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

Mount Sinai | MSSM MOUNT SINAI SCHOOL OF MEDICINE | Mount Sinai North Shore Medical Group | Mount Sinai The Mount Sinai Hospital of Queens A Division of The Mount Sinai Hospital | Mount Sinai Diagnostic and Treatment Center

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