School-Based Health Program

Your child can receive medical services without missing a day of school! It's fast and easy!

We are happy to inform you that your child's school has an on-site School-Based Health Center (SBHC)! The SBHC is staffed by licensed health professionals from Urban Health Plan.

Urban Health Plan (UHP) is a network of community health centers in the Bronx, Queens and Harlem. We have provided quality, affordable primary and specialty care in the Bronx community for over 45 years.

At the SBHC, your child can get medical services at **no cost** to you, regardless of insurance status.

In order for you to get healthcare services, the following forms must be completed, signed and returned to the School Based Health Center:

- Consent Form
- Medical History Form
- Release of Medical Information Form

Signing the consent form:

- **Does not** change your insurance plan
- **Does not** change your doctor
- **Does not** affect the number of times you can see your doctor

School-Based Health Center Hours:
Monday - Friday: 8:30 a.m. - 3:30 p.m.

School-Based Health Center Services Include:

- Care for Chronic Medical Conditions
- Administer Medication
- Annual Physical Exams
- Form Completion (summer camp, after school, working papers & sports forms)
- Basic Laboratory Tests, Blood/Urine Tests
- Immunizations (Vaccines)
- First Aid
- Mental Health Counseling
- Nutrition and Health Education
- Dental Services (at some locations)
- Referrals for Health Insurance if needed
- Age appropriate reproductive health care
- Screening for vision, hearing, asthma,obesity, and other medical conditions

Urban Health Plan provides 24-hour on-call services to all of their SBHC patients. To reach a medical provider in the evenings or on weekends, call (718) 589-2440.

Urban Health Plan, Inc.
School-Based Health Program

Parental Consent for Medical and Dental Services

Please know that your child can use the School Based Health Center and see your other doctors. Signing this consent form DOES NOT change your insurance, DOES NOT change your prívate doctor, and DOES NOT affect the number of times your child can see their prívate doctor.

Student Information

Student's LAST Name: ______________________________

Student's FIRST Name: ______________________________

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

Sex: ❑ Male ❑ Female
Gender Pronouns: ❑He/Him ❑ She/Her ❑They/Them

Ethnicity
❑ Hispanic ❑African American ❑ Asian/Pacific Islander
❑ White ❑ American Indian ❑Other ____________

***Social Security Number**: ________________________
(*optional field: used to verify medical insurance only)

Student Address: ______________________________
________________________**Zip Code**________________

Telephone Number ______________________________

Which school is your child registered in?

____

Parent/ Legal Guardian Information

Parent/Legal Guardian
Last Name: ________________ First Name: ______________
Home/Cell: _________________Work Tel: ______________

If you are the Legal Guardian, what is your relationship to the student? _ ____________________

Preferred Language of Communication: ________________

Preferred Method for Reminders:
❑ Email ❑ Text Messages

Emergency Contact

Name: ____
Relationship to Student: _________________________________
Home: ____________________ Cell:______________________

Medical Information

Name of Primary Care Doctor: ____________________________
Address:____
Telephone Number :_____________________________________
Last Physical Exam: ____________________________________

Dental Information

Name of Dentist:_______________________________________
Telephone Number: ____________________________________
Last Dental Visit: ______________________________________

Pharmacy Information

Please indicate the pharmacy where we can send the prescriptions for your child

Pharmacy Name: _________________________________
Pharmacy Address: ______________________________
Pharmacy Phone number: ___________________________

Health Insurance Information

Does the student have MEDICAID? ❑ Yes ❑ No
Medicaid # ______________________ Seq.# ______________

Does your child have another type of Health Insurance? ❑ Yes ❑ No

Name of insurance Plan:___________________________________

Member ID or Policy Number:______________________________

If your child does not have health insurance, would you like to be contacted by a health insurance enroller? ❑ Yes ❑ No

What is the best time to contact you? _______________________

Box #1 Parental Consent for Services Received at the School Based Health Center

I have read and understand the services listed which include Dental Services on the next page (School Based Health Center Services). My signature on the yellow line provides consent for my child to receive all services provided by ***Urban Health Plan, Inc. School-Based Health Center.***

❑ Please check this box and sign here if you **DO NOT** want your child to receive DENTAL Services ____________________________

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, married or legally emancipated. My signature indicates that I have received a copy of the Notice of Privacy Practices (last page of packet). My signature also gives my consent to contact other providers who have examined my child.

X____ ____________________

Signature of Parent/Legal Guardian **Date**

Box #2 HIPPA Compliant Parental Consent for Release of Health Information

I have read and understand the release of health information on the following page. My signature indicates my consent to release medical information as specified in box #2 on the next page.

X____ ____________________

Signature of Parent/ Legal Guardian **Date**

Urban Health Plan, Inc.
School-Based Health Program

BOX #1 SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of **URBAN HEALTH PLAN, INC.** 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. For Adolescent Students: Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot), LARC, among other FDA approved methods] testing for pregnancy, STD screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, smoking abuse, education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Dental examinations including: diagnosis, treatment, and sealants where available. *Please be sure to sign the Red line on the front page if you Do Not want your child to receive DENTAL services at school.*
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.

BOX #2 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 first page of this packet authorizes the 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 **URBAN HEALTH PLAN, INC.** 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 including but not limited to:

*Comprehensive Physical Exam
(Form CH-205 or equivalent sports exams, etc.)
* Vision and hearing screening results
* Immunizations (required /recommended)
* Tuberculin Test Results

Information to Protect Health and Safety:

* Conditions which may require emergency medical treatment including chronic illness
* 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).
* Health insurance coverage
* Enrollment in School-Based Health Center
* Individualized Education Program (IEP)

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

Note:* *This school Based Health Center Parental Consent Form has been approved by DOE/OSH

Revised 07/30/19

Urban Health Plan, Inc.
School-Based Health Program

Preliminary History Form

Student's Name ________________________ **Date of Birth** ________________ **Name of School**____________________

Child's Medical History

Does your child have any medical conditions? () Yes () No
If yes, please specify? ______________________________

Has your child ever been hospitalized or had any surgeries? () Yes () No
When? ___________________________________
Hospital? ________________________________
Why? ______________________________________

Does your child have any allergies to any **foods or Medication (s)**? () Yes () No
If yes, what are they?_______________________________

Does your child take any medication? () Yes () No
If yes please list: _________________________________

How would you rate your child's health in general?
(A) Excellent (B) Good (C) Fair (D) Poor

Child's Social History

Where is your child living at now?
(A) House (B) Apartment (C) Shelter (D) other _________

Does anyone in your household smoke? () Yes () No

Do you feel that you live in a safe place? () Yes () No

Does your child seem sad or worried? () Yes () No

Has your child ever talked about wanting to hurt him/herself or hurt others? () Yes () No

Do you have any concerns about any of the following?

Your Child's Behavior? () Yes () No

Developmental (Learning) capability? () Yes () No

Depression or any other concern? () Yes () No

Family Medical History

Does anyone in the family have any of the following medical conditions? If yes, who?

Asthma () Yes () No ________________________

Diabetes () Yes () No ________________________

High Blood Pressure () Yes () No ___________________

Drug/Drinking Problems () Yes () No _________________

Mental Illness () Yes () No ______________________

Heart Problems ()Yes () No _____________________

Other _______________________

Family Beliefs

Are there any beliefs or practices that we should know of while providing services to your child at the SBHC? ()Yes () No

If yes, please specify_______________________________

School Based Health Clinic Billing Policy

At the SBHC, your child can receive all services at **NO Cost** to you. Although the SBHC is allowed to bill your medical insurance, we will **Not change** your primary medical doctor and we will **Not charge** a co-pay. If you happen to get a bill, it is an error and should be brought to our attention for correction.

If your child does not have medical insurance, would you like to be contacted by a health insurance enroller? ()Yes () No

What is your family/ household size? ___________________

What is your combined family/household gross income? ________________________________

Urban Health Plan, Inc.
School-Based Health Program

HIPAA Release of Medical Information

Dear Parent/Guardian:

In order to better coordinate the care provided to your child, we are required to inform your child's doctor that his/her patient is enrolled in the School Based Health Center (SBHC). Signing this form will allow us to better coordinate comprehensive medical care with his/ her physician. It **does not** change your medical insurance plan and it **does not** change your child's doctor. Please complete the following information.

I Authorize (**Doctor's Name**)____________________________ to release any medical information including but not limited to current treatment plans and most recent Physical Exam about (**child's Name**) ____________________________________(child's **date of birth**)_______________to the Urban Health Plan, Inc. School Based Health Center.

As the parent, I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed below. I may revoke this authorization except to the extent that action has already been taken based on this authorization.

X________________________________
Parent/ Guardians Signature and date

Upon Graduation
Expiration Date of Event

Dear Doctor:

Your patient, ____________________________ (D.O.B.) ____________ has enrolled in the Urban Health Plan, Inc. School Based Health Center located at (School Name) __________________________________. The school based health center can provide the following services while the student is at school **without** having to change their Primary Care Provider. These services will not affect the PCP's visits for capitation.

Services offered at the SBHC include but are not limited to: Well Visits, sick visits, immunizations, Physical exams, routine screenings, labs, medication administration and chronic care follow up.

The parent has authorized for you to release the following information about your patient: Last Physical Exam, most recent blood work, medical summary, and a list of medication (If any).

Please send the information to:

Urban Health Plan Inc.
Health Information Management Department
1065 Southern Blvd, Bronx, NY 10459
Or via Fax to 718-617-7943

CONFIDENTIALITY SAFEGUARDS: In compliance with HIPAA, confidentiality mandates permission for this personal health information has been obtained by the patient, and as such, this letter should be treated as highly confidential records and not shared without the patients permission.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
•For workers' compensation claims
•For law enforcement purposes or with a law enforcement official
•With health oversight agencies for activities authorized by law
•For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
•We are required by law to maintain the privacy and security of your protected health information.
•We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
•We must follow the duties and privacy practices described in this notice and give you a copy of it.
•We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services
We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Parental Access
State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act according to the laws of New York and will make disclosures following such laws.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Your Information.
Your Rights.
Our Responsibilities.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your "Protected Health Information" (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices is NOT an authorization.
There are several other privacy laws that also apply to HIV-related information, family planning, mental health, psychotherapy notes, and substance abuse information. The release of such information is subject to stricter privacy standards and requires express permission from you.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
If you have any questions about this form, please ask to speak to our Privacy Officer in person or by phone at our main phone number of (718)-589-2440.

Your Rights

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record

Request confidential communication

- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

Treat you

- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the UHP Privacy Officer at (718) 589-2440.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not get back at you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.
- We never sell personal information.

Our Uses and Disclosures

How do we usually use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that serve the public good. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Your Information.
Your Rights.
Our Responsibilities.

www.urbanhealthplan.org