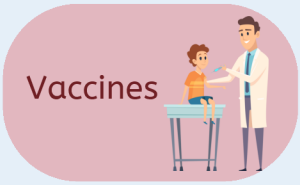
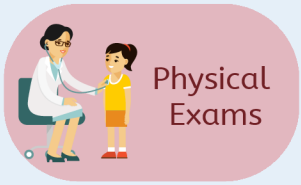
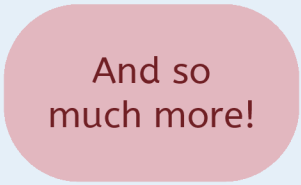
School Health Center Services

Dear Parent/Guardian,

Our School Based Health Center (SBHC) is dedicated to providing comprehensive health care services to all students on this campus. SBHC services include the following:







What is a School Based Health Center (SBHC)?

A school-based health center is a medical facility inside your child's school building, sponsored by a local hospital or health center, to provide primary care services to all students who attend the schools on campus.

What if my child already has a primary doctor?

You **DO NOT** need to change your primary doctor for your child to receive services at the SBHC. The SBHC provider will compliment the care that their primary doctor provides.

How can my child use the SBHC services?

Complete a consent form to enroll your child in the SBHC! This will allow your child to receive comprehensive health services in their school building, minimizing their time away from class and your time away from work. Without enrolling in the SBHC, your child will only be able to access limited services (first aid, emergency care, vaccines).

What is the cost? Does my child need health insurance?

At the SBHC, your child can receive services at **NO COST** to you! The SBHC will treat your child regardless of insurance status. The SBHC is allowed to bill your insurance but you will not receive a bill or be responsible for any copays. If you need help to apply for health insurance for your child, speak to someone at the SBHC.

What if my child does not have a Social Security Number? Can they still be enrolled in the SBHC?

YES! All students can enroll into the SBHC, including those who are immigrants or do not have a social security number. The SBHC might ask for a social security number to check for insurance, but it is not necessary to receive services at the SBHC.

Feel free to come visit our health center in Room B06 or call (718) 834-2981 for more information.

Revised 10/03/2023

It's fast and easy for your child to receive health care services through the Brooklyn Plaza Medical Center, Inc School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that your child's school has a School Based Health Center (SBHC)! The SBHC is staffed by licensed professionals from **Brooklyn Plaza Medical Center, Inc.**

Please know that your child can use the School-Based Health Center and see their other doctors as well. Signing this consent does not change your child's insurance, does not change your child's primary doctor, and does not affect the number of times your child can see their primary doctor.

At the School Based Health Center, your child can receive the services listed below at **no cost**, regardless of insurance status. However, the SBHC is allowed to bill insurance if your child has health insurance. There are **no co-pays** for SBHC services, and **you will never receive a bill.** If your child has health insurance, please complete the insurance information section on the attached consent form.

School Based Health Center Services include:

- Primary Care Services
  - Physical Exams (including for sports and working papers)
  - Vaccinations
  - Medications and Prescription Management
  - Laboratory Tests
  - Screening for vision, asthma, and other medical conditions
  - Treatment for acute and chronic conditions
  - For Adolescents: Age-appropriate reproductive health services
- Health Education
- Mental Health Counseling
- Dental Services (where available)
- Telemedicine Virtual Visits (where available)

The School Based Health Center is located in room B06 of your child's school and is open every school day between the hours of 8am –4 pm. Access to an on-call provider is also available on weekends and after hours.

To register your child, please **read, complete, and sign** the attached enrollment form. Please provide a copy of your child's most recent **annual physical exam form** (within the last 12 months) if available. If you do not have a copy, please sign the HIPAA release form to allow us to retrieve pertinent medical information from your child's primary care provider. You or your child can return the completed enrollment form to the School-Based Health Center in room B06. If you have any questions, please call us at **718-834-2981**.

We look forward to meeting you and providing health services to your child!

Sincerely,

Dr. Pascale Kersaint, MD
Chief Medical Officer
Brooklyn Plaza Medical Center, Inc

Dr. Kinsley Kwateng, Ph.D
Principal
Benjamin Banneker Academy for Community Development

School Based Health Center Parental Consent Form

Health Care Service Provider address: *Brooklyn Plaza Medical Center, Inc- 650 Fulton Street, Brooklyn NY 11217*
Name of School(s)*: Benjamin Banneker Academy for Community Development- 77 Clinton Ave, Brooklyn NY 11205*

Please know that your child can use the School-Based Health Center and see their other doctors. Signing this consent does not change your child's insurance, does not change your child's primary doctor, and does not affect the number of times your child can see their primary doctor.

STUDENT INFORMATION

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Student Address: _____
_____
City State Zip Code
School: _____ **Grade:** _____
Student ID # (OSIS): _____
Student Cell Phone: _____
Student Email: _____
***Student Social Security Number:** _____
Optional field: Used for insurance purposes only
Sex at Birth: ❑ Male ❑ Female **Pronouns:** _____
Gender Identity (*check all that apply*): ❑ Male ❑ Female
❑ Non-Binary ❑ Transgender ❑ Other: _____
Race (*check all that apply*): ❑ Black/African American ❑ White ❑ Asian
❑ Multiracial ❑ Native Hawaiian/Pacific Islander
❑ American Indian/Alaska Native ❑ Other _____
Ethnicity: ❑ Hispanic or Latino/a ❑ Not Hispanic or Latino/a

PARENT INFORMATION

Parent/Legal Guardian:
Last Name: _____ First Name: _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

Parent/Legal Guardian:
Last Name: _____ First Name: _____
Home/ Work Tel: _____
Cell Phone: _____
Email: _____

If legal guardian, relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: _____
Preferred Language of Parent/Guardian: _____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Telephone: _____

HEALTHCARE PROVIDER INFORMATION

Does your child have a regular doctor? ❑ Yes ❑ No
Name: _____
Practice/Clinic Name: _____
Telephone: _____
Address: _____

Does your child have a regular dentist? ❑ Yes ❑ No
Name: _____
Practice/Clinic Name: _____
Telephone: _____
Address: _____

INSURANCE & PHARMACY INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # _____
Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # _____
Does your child have other health insurance?
❑ No ❑ Yes, Health Plan: _____
Member ID/Policy Number: _____
Name of the Insured: _____

Indicate the Pharmacy where we can send prescriptions.
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____

If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance? ❑ No ❑ Yes
What is the best time to contact you? _____

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER PRIMARY CARE SERVICES

I have read and understand the services listed in Box 1 on the next page and my signature provides consent for my child to receive services provided by the BROOKLYN PLAZA MEDICAL CENTER School-Based Health Center. My signature indicates I have received a copy of the Notice of Privacy Practices and also gives my consent to contact other providers who have examined my child.
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, married, legally emancipated, or runaway or homeless youth.

X _____ _____
Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in Box 2 on the next page and my signature indicates my consent to release medical information as specified in the Box 2 section only.

X _____ _____
Signature of Parent/Guardian **Date**

Box 3. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER DENTAL SERVICES

I have read and understand the dental services listed in Box 3 attached and my signature provides consent for my child to receive the listed dental services provided by the BROOKLYN PLAZA MEDICAL CENTER, INC School-Based Health Center.

X _____ _____
Signature of Parent/Guardian **Date**

School Based Health Center Parental Consent Form

SCHOOL BASED HEALTH CENTER SERVICES **BOX 1**

I consent for my child to receive health care services provided by the State-licensed health professionals of BROOKLYN PLAZA MEDICAL CENTER, 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 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. Mandated school health services, including screening for vision, hearing, asthma, obesity, scoliosis and other medical conditions, first aid, and required and recommended immunizations (additional permission required for 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, other FDA approved methods] testing for pregnancy, STI screening and treatment, HIV testing, and referrals, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: smoking and drug or alcohol use, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Oral health screening, fluoride treatment, where available.
9. Referrals for services not provided at the school-based health center.
10. Annual health questionnaire/survey.

NEW YORK CITY DEPARTMENT OF EDUCATION'S HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION **BOX 2**

My signature on the reverse side of this form authorizes release of health information as specified below. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing health information as specified below to be given to the 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 health 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 BROOKLYN PLAZA MEDICAL CENTER, INC School-Based Health Center to release specific health information of the student named on the reverse page to the 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.

I understand that information to be released to the NYC 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 my child, includes but is not limited to:

Comprehensive Physical Exam (Form CH-205 or Equivalent) Immunizations (required/recommended) Vision and hearing screening results	Any Other Information deemed Necessary to Protect a Student's Health or Safety
Diagnosis of Chronic Illness (including *Medication Administration Forms* or *Diabetic Medication Administration Forms*) Conditions which limit a student's daily activity	Information required to complete the DOE Incident Report or Office of School Health Principal Communication Form for OORS Reporting.
Diagnosis of certain Communicable Diseases (**does NOT include HIV/STI information)**	Conditions that require transport to an Emergency Department
Individualized Education Program (IEP) documents	Health Insurance Coverage Enrollment in School-Based Health Center

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

School Based Health Center Parental Consent Form

SCHOOL-BASED HEALTH CENTER DENTAL SERVICES BOX 3

I consent for my child to receive dental treatment provided by the licensed professionals of Brooklyn Plaza Medical Center, Inc as part of the school-based dental program approved by the New York State Department of Health. School-Based Health Center preventative dental services may include:

1. Examination/screening by a dentist or dental hygienist
2. Teeth cleaning
3. Dental sealants
4. Fluoride treatment
5. Silver Diamine Fluoride (SDF), where available*: SDF may be applied on back teeth to halt the progression of cavities. It may discolor any cavities resulting in a brown or black color.*
6. Dental X-rays, where available (if needed)
7. Referrals (if needed)

For services other than the preventative dental services listed above, the HCSP will notify the parent/guardian of the recommended services and treatments for their child **before** they are provided. Based on the child's needs, these may include fillings, extractions, and the use of anesthetics or other medications.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Primary Care Provider/Specialist

8. Name and address of person(s) or category of person to whom this information will be sent: Tel:(718) 834-2981, Fax:(877) 460-4752
Brooklyn Plaza Medical Center, SBHC: Benjamin Banneker Academy, 77 Clinton Ave Rm B06, Brooklyn, NY 11205

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:
_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**Graduation or the date/event I have listed:**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: **Mother/Father/Legal Guardian**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Brooklyn Plaza Medical Center, School-Based Health Center: Benjamin Banneker Academy
77 Clinton Avenue Room B06, Brooklyn, NY 11205
Phone: (718) 834-2981 Fax: (718) 834-4782

MEDICAL HISTORY FORM

Student Name: _____ **Date of Birth:** _____

MEDICATIONS

Does your child take any medication? (including albuterol)
☐ Yes ☐ No
If yes, please list their names and dosages below

Medication	**Dosage**
_____	_____
_____	_____
_____	_____

If your child brings medication to school i.e. EpiPen, please complete a medication administration form with their doctor**

<u>All parents</u>: If your child is sick and needs medication, where would you like us to send the prescription?
Preferred Pharmacy Name:
_____

Pharmacy Phone# and/or Address:
_____
_____
_____

ALLERGIES

Is your child allergic to any food or medication?
☐ Yes ☐ No
If yes, please list what substances and type of reaction

Substance	**Reaction** (i.e. hives, rash)
_____	_____
_____	_____
_____	_____

Does your child have an EpiPen? ☐ Yes ☐ No
If yes, please complete a medication administration form**
Do you want your child to get an EpiPen? ☐ Yes ☐ No
To see the dentist, please mark if your child is allergic to any of these specific items:

Aspirin	☐ Yes	☐ No
Barbiturates (sleeping pills)	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthetic	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No

FAMILY HISTORY

Please mark with an "**X**" or "✓" if anyone related to your child by blood has/had any of the following:

Condition	Father	Grandfather father's side	Grandmother father's side	Mother	Grandfather mother's side	Grandmother mother's side
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Blood disorder/sickle cell anemia	☐	☐	☐	☐	☐	☐
Sudden/unexplained death < 50 years old	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐

SURGERIES/HOSPITALIZATIONS

Has your child had any surgeries, including oral surgeries?	☐ Yes ☐ No	If yes, what kind of surgery? _____ Month & year of surgery: _____
Has your child ever been hospitalized overnight?	☐ Yes ☐ No	If yes, why? _____ Month, year, & length of stay: _____

**Medication administration forms for asthma, allergies, diabetes, seizure, etc. are available at www.schools.nyc.gov or upon request from the school 504 coordinator or school-based health center

HEALTH HISTORY

When was your child's last annual physical exam? (_____/_____) ☐ Unsure
Month Year

When was your child's last dental exam? (_____/_____) ☐ Unsure
Month Year

Please mark if you child has/had any of the following:

ADHD/Learning Disability	☐ Yes	☐ No	Diet Restrictions	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Allergies**	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia (low iron)	☐ Yes	☐ No	Epilepsy/seizure**	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headache/Migraine	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma**	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding Abnormalities	☐ Yes	☐ No	Hepatitis (liver disease)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet/Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Congestion Heart Lesions	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head/neck	☐ Yes	☐ No
Cough, persistent	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease or STI/STD	☐ Yes	☐ No
Diabetes**	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No

If you marked yes for an item, is there anything else you'd like us to know about this condition?

_____

Has your child ever used bisphosphonate medication? I.e. Fosamax, Actonel, Atelvia, Didronel, Boniva
☐ Yes ☐ No

Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonmin, Adipex, Fastin, brand names of Phentermine, Pondimin (fenfluramine), and Redux (dexfenfluramine)
☐ Yes ☐ No

PARENT/LEGAL GUARDIAN SIGNATURE

I have reviewed this form with my child, and I have completed it to the best of my knowledge.

Parent/Legal Guardian Signature_____ **Date**_____
(or student if 18 years or older or otherwise permitted by law)

Parent/Legal Guardian Name (Please Print)_____
(or student if 18 years or older or otherwise permitted by law)

**Medication administration forms for asthma, allergies, diabetes, seizure, etc. are available at www.schools.nyc.gov or upon request from the school 504 coordinator or school-based health center