

**NYU LANGONE HOSPITALS
HEMPSTEAD HIGH HEALTH CENTER**

201 President Street Hempstead, NY 11550

(516) 434-4251

A Joint Program of the Hempstead School
District and NYU Langone Hospital – Long Island
Parental Consent for Health Services

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

STUDENT INFORMATION	PARENT INFORMATION
<p>Student Last Name: _____</p> <p>Student First Name: _____</p> <p>Date of Birth: _____ / _____ / _____ <small>Month Day Year</small></p> <p>Student Address: _____ _____ <small>City State Zip Code</small></p> <p>Student email: _____</p> <p>*Student Social Security Number: _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Grade _____</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>List the student's regular doctor, if they have one? Name: _____ Telephone: _____ Address: _____</p> <p>Indicate the Pharmacy where we can send prescriptions. Pharmacy _____ Pharmacy Address: _____ Pharmacy Tel: _____</p> <p>*Indicates optional field: Used for insurance purposes only</p>	<p>Parent/ Legal Guardian: Last Name: _____ First Name: _____ Home/Work Tel: _____ Cell Phone: _____ Email: _____</p> <p>Parent/Legal Guardian: Last Name: _____ First Name: _____ Home/ Work Tel: _____ Cell Phone: _____ Email : _____</p> <p>If legal guardian , relationship to the student: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____ Home /Work Tel: _____ Cell: _____ Email: _____</p> <p>Preferred Language of Parent/ Guardian: _____</p> <div style="background-color: #cccccc; text-align: center; padding: 2px;">ADDITIONAL EMERGENCY CONTACT</div> <p>Name: _____ Relationship to Student: _____ Home or Work Tel: _____ Cell: _____</p>

INSURANCE INFORMATION	
<p>Does your child have Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes: Medicaid ID # _____</p> <p>Does your child have Child Health Plus? <input type="checkbox"/> No <input type="checkbox"/> Yes: CHP # _____</p> <p>Which Plan? <input type="checkbox"/> Affinity <input type="checkbox"/> Fidelis <input type="checkbox"/> Healthfirst <input type="checkbox"/> Empire BC/BS Health Plus <input type="checkbox"/> Emblem Health(HIP/GHI) <input type="checkbox"/> Metro Plus <input type="checkbox"/> WellCare <input type="checkbox"/> United Healthcare</p>	<p>Does your child have other health insurance <input type="checkbox"/> No <input type="checkbox"/> Yes, Health Plan: _____</p> <p>Member ID/Policy Number: _____ Health Insurance Phone: _____</p> <p>If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes What is the best time to contact you? _____</p>

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

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 Hempstead High Health Center at NYU Langone Hospital – Long Island School-Based Health Center. 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 or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child. My signature indicates my consent to release medical information.

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X _____	_____
Signature of Parent/Guardian	Date

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE PROVIDER FOR SERVICES RENDERED.
I AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION ABOUT THIS CLAIM. A PHOTOCOPY
OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

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PARENTAL CONSENT FOR HEALTH SERVICES

I hereby give my consent for my son/daughter (indicated above) to receive “no cost” health care provided by the physician, nurse practitioner and other State-licensed health professionals of the Hempstead High Health Center, as well as low cost care at NYU Langone Hospital – Long Island Pediatric Center. This care includes the following health care services as part of a school health program sponsored by the New York State Department of Health:

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, 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, nutrition and substance abuse counseling, asthma education
7. Reproductive health care services, including abstinence counseling, contraception counseling, testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
8. 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 and medically indicated.
9. Dental examinations including: diagnosis and sealants as appropriate
10. Referrals for service not provided at the school-based health center.
11. Annual health questionnaire/survey.
12. Provision of health services at the NYU Langone Hospital – Long Island Pediatric Center during after school hours and school vacations.

I grant permission for my child to enroll in the Hempstead High Health Center. I understand that, when necessary, efforts will be made to contact me before any treatment that requires parental consent according to New York State Law is given. I understand that confidentiality between the student and the medical team will be ensured in specific service areas and will not be discussed with the parent or guardian unless the student agrees. The staff of Hempstead High Health Center considers parental involvement important. Staff encourages students to involve their parents or guardians in counseling and medical care.

“No cost” insurance means no out-of-pocket expenses. When students are covered by health insurance, the insurance companies are billed.

<p>Parent or Guardian Signature: _____</p> <p>Print Name: _____ Date: _____ Time: _____ AM / PM</p>
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