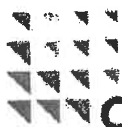

Cohen Children's Medical Center
Northwell Health℠

School-Based Health Program

**Steven and Alexandra Cohen
Children's Medical Center
Division of Adolescent Medicine
410 Lakeville Road, Suite 108
New Hyde Park, New York 11042**

It's fast and easy for your child to receive health care services through the Cohen Children's Medical Center School-based Health Center (SBHC)!

Dear Students, Parents/Guardians and School Staff:

We are happy to inform you that the August Martin Campus has a School Based Health Center! The SBHC is run by **Cohen Children's Medical Center** (CCMC) and is part of the hospital's Adolescent Medicine Division. The SBHC is staffed by CCMC's licensed professionals consisting of medical, mental health and health education providers, offering all medical and mental health services at no cost to you, regardless of your insurance status.

Please know that your child can use the School-Based Health Center and see your other doctors as well. 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 primary doctor.

At the School Based Health Center, your child can receive the services listed below. The SBHC may bill Medicaid to support our services, however there are **no co-pays for you**, and **you do not receive a bill.** Enrollment in the SBHC includes access to CCMC Adolescent Medicine physicians 24 hours/day, 7 days per week via on-call system.

School-based Health Center Services include:

- Medical care, including treatment for acute and chronic conditions;
- Mental health services, including crisis intervention, individual and group counseling;
- Annual physical examinations and forms for sports, working papers or college;
- Screening for vision, weight management, asthma and other medical conditions;
- Immunization updates with your consent
- Medical laboratory tests, as needed;
- Medications both on-site and by prescription;
- Reproductive health care, as needed; Health Education Counseling
- Screening and referral for health insurance

Attached to this letter is a consent form for you to sign that will allow your son/daughter to use our services at the School-based Health Center. To register your son/daughter for the School-based Health Center, please:
Complete the information on the attached "NYC School Health Program Parental Consent Form".
Sign and date in both places at the bottom of the form.
Then give the form to your son/daughter to bring to room 116.

Thank you

Sincerely,

Linda Carmine, MD	Tiffany LaSister, RN, FNP-BC	Rachel Lindheim, LCSW
SBHC Program Director	SBHC Site Coordinator	SBHC Mental Health Coordinator

Cohen Children's Medical Center School Based Health Center Parental Consent Form

Health Care Service Provider: *Division of Adolescent Medicine, 410 Lakeville Road, Ste 108, New Hyde Park, NY 11042*
Name of School(s): *_August Martin Campus_____________________________*

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

STUDENT INFORMATION

Student Last Name: ______________________
Student First Name: ______________________
Date of Birth: ________/________/________
Month Day Year
Student Address:______________________
____
City State Zip Code
Student cell # :______________________

***Student Social Security Number:** ______________________
Sex: ❑ Male ❑ Female Grade ________

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other ________
List the student's regular doctor, if they have one?
Name: ______________________
Telephone: ______________________
Address: ______________________

Indicate the Pharmacy where we can send prescriptions.
Pharmacy______________________
Pharmacy Address: ______________________
Pharmacy Tel: ______________________
***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

<u>Parent/ Legal Guardian:</u>
Last Name: ____________ First Name: ____________
Home/Work Tel: ______________________
Cell Phone: ______________________
Email: ______________________

<u>Parent/Legal Guardian:</u>
Last Name: ____________ First Name: ____________
Home/ Work Tel:______________________
Cell Phone:______________________
Email :______________________

If legal guardian , relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: ________
Home /Work Tel: ______________________
Cell: ______________________
Email: ______________________
Preferred Language of Parent/ Guardian:______________________

ADDITIONAL EMERGENCY CONTACT

Name: ______________________
Relationship to Student: ______________________
Home or Work Tel:______________________
Cell: ______________________

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # ______________________
Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # ______________________
Which Plan?
❑ Affinity
❑ Healthfirst
❑ Emblem Health(HIP/GHI)
❑ WellCare
❑ Fidelis
❑ Empire BC/BS Health Plus
❑ Metro Plus
❑ United Healthcare

Does your child have other health insurance
❑ No ❑ Yes, Health Plan: ______________________
Member ID/Policy Number: ______________________
Health Insurance Phone: ______________________
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 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 <u>COHEN CHILDREN'S MEDICAL CENTER</u> 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.

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 reverse side of this form. My signature indicates my consent to release medical information as specified in the box 2 section only.

X ______________________________ ____________
Signature of Parent/Guardian **Date**