School-Based Health Center PROGRAM

Syracuse Community Health Center, Inc.

Syracuse City School District

Delaware	**315-435-4452**	**Grant**	**315-435-4040**
Dr Weeks	**315-435-4030**	**HW Smith**	**315-435-6266**
PSLA @ Fowler	**315-435-4410**	**STEAM @ Dr King**	**315-435-4031**
Franklin Magnet	**315-435-4102**	**STEM @ Blodgett**	**315-435-6431**

Did you know…your child can receive medical, dental, and behavioral health services while they are at school?

Syracuse Community Health Center, Inc. (SCHC) has partnered with the Syracuse City School District (SCSD) to offer a full range of services at your child's school through the **School Based Health Center (SBHC) Program** including:

- Physicals and check-ups (sports and work paper exams)
- Immunizations
- Prescriptions
- Treatment of acute and urgent sickness or minor injuries
- Dental cleanings, sealants, x-rays and treatments
- Mental Health counseling

The SBHC operates year-round, during and after regular school hours, including holidays and summer vacations. When the SBHC is closed, walk-in care is available at SCHC's main site, 819 South Salina Street, Syracuse, NY 13202. Visit the Location/Hours tab on SCHC's website (https://www.schcny.com) for more information regarding services/hours at our different locations and after-hours care. Services provided at the SBHC have **no out-of-pocket costs to you**, regardless of your child's insurance coverage!

- If your child is insured we will bill your insurance, but you are not responsible for any typical co-pays associated with the office visit (even for mental health and dental services).
- If your child is uninsured, not only will you not receive a bill, but a member of our team will reach out to you in an effort to get your child and the rest of your family set up with coverage for the future.

Please note that you may be responsible for the cost of health care services provided outside of the SBHC, such as after-hours care or referrals.

Already have a Primary Care Physician (PCP)?

No problem! Many of the children we serve are already followed by a PCP. The goal of the SBHC is not to interfere with that relationship and you will not be penalized in any way for enrolling in the program. SBHC works in partnership with the SCSD and existing PCP, if there is one, to ensure that your child has all the tools they need to be successful.

If your child already has a PCP, we will communicate with their office to ensure the continuity of care for your child. If your child is seen for an acute illness/injury at the SBHC, they will receive the care they need immediately, allowing them to then follow-up with their PCP at a more convenient time.

Enrolling your child in the SBHC does not give them an obligation to be seen; the SBHC enrollment can serve as a back-up for unexpected issues while your child is at school. We will request proof of an annual physical for your child from their PCP to keep on file if the physical is not completed at the SBHC.

If your child **does not** have a current PCP, the SBHC can also serve that purpose for you. Many parents appreciate the convenience of the SBHC for routine visits that may otherwise be hard to accommodate due to things like work schedules and or transportation barriers.

A healthy child is key to learning and growing, that's why we are working to make access to care as convenient as possible. We strongly believe that no child should experience academic difficulties resulting from a lack of health-related care. Please call the number listed above to speak with the SBHC staff at your child's school or go to our website listed above for more information.

Please complete the attached enrollment packet and return it to school with your child in order for them to be enrolled in the program. This is a one-time enrollment that will remain in effect throughout their time in the district, or for as long as they attend a building where our SBHCs are located.

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BASIC HEALTH HISTORY

Child's Name: _____ **Date of Birth:** _____**Today's Date:** _____

Who does your child live with most of the time (check all that apply)?

- ☐ Both parents
- ☐ Mother only
- ☐ Father only
- ☐ Stepmother
- ☐ Stepfather
- ☐ Brothers and sisters
- ☐ Other children
- ☐ Foster Parent
- ☐ Grandparent
- ☐ Other _____

Have there been any significant changes at home in the past year (check all that apply)?

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of a job
- ☐ Move to a new place
- ☐ Move to a new school
- ☐ Births
- ☐ Serious illnesses
- ☐ Deaths
- ☐ Other _____

Smoking History (check all that apply):

- ☐ My child smokes/vapes or chews
- ☐ Someone else in the household smokes

Does your child take any medications?

- ☐ No
- ☐ Yes (please list): _____

Is your child allergic to any medications?

- ☐ No
- ☐ Yes (please list): _____

Is your child allergic to any foods?

- ☐ No
- ☐ Yes (please list): _____

Does your child have an Epi-pen?

- ☐ No
- ☐ Yes

Does your child have a history of any of the following?

- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD)
- ☐ Depression
- ☐ Anxiety
- ☐ Heart Murmur
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia

Has your child ever had chicken pox?

- ☐ No
- ☐ Yes

Has your child ever been hospitalized or had a surgery?

- ☐ No
- ☐ Yes (please describe): _____

Tuberculosis (TB) Screening (please check any applicable boxes below):

- ☐ My child has been diagnosed with TB in the past
- ☐ My child has had known exposure to someone with TB
- ☐ My child has lived in the US for less than 5 years
- ☐ My child has spent more than one month outside of the US

Is there a family history of any of the following (if yes, please check box and list relation)?

- ☐ Asthma: _____
- ☐ Diabetes: _____
- ☐ Heart Attack or Stroke before age 45: _____
- ☐ High Cholesterol: _____

Is there anything else you would like us to know about your child?

_____

_____

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Enrollment Demographics and Consent

SBHC Location:

- ☐ Delaware
- ☐ Dr Weeks
- ☐ PSLA @ Fowler
- ☐ Franklin Magnet
- ☐ Grant
- ☐ HW Smith
- ☐ STEAM @ Dr King
- ☐ STEM @ Blodgett

Student's Current Grade: _____

What services are you interested in having your child receive at the SBHC?

- ☐ Medical Only
- ☐ Medical and Dental

Patient Demographic Information:

Student's Full Name: _____ **Date of Birth (DOB):** _____

Social Security Number: _____ **Mother's Maiden Name:** _____

Street Address: _____ **Zip Code:** _____
PO Box: _____ **City:** _____

Parent/Guardian Name: _____ **Parent/Guardian DOB:** _____

Parent/Guardian Contact Number #1:
_____

Parent/Guardian Contact Number #2:
_____

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race/Ethnicity:

- ☐ Hispanic/Latino
- ☐ Black
- ☐ White
- ☐ American Indian
- ☐ Asian/Pacific Islander
- ☐ Other: _____

Current Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Non-binary

Gender at Birth:

- ☐ Male
- ☐ Female

Preferred Pharmacy Name/Address/Phone:
_____
_____

Emergency Contact Name/Relationship: _____ **Contact Number:** _____

Insurance:

Medical Insurance (select applicable and provide insurance ID #):

- ☐ Medicaid: _____
- ☐ United HealthCare: _____
- ☐ Fidelis: _____
- ☐ Molina: _____
- ☐ Other (please specify name, ID, and subscriber):
  _____
- ☐ No medical insurance

Dental Insurance (select applicable and provide insurance ID #):

- ☐ Dental is the same as medical
- ☐ Other (please specify name, ID, and subscriber):
  _____
- ☐ No dental insurance

Patient Name: _____

Outside Primary Care Provider (PCP) Information (please select):

☐ My child already has a PCP (please list name, address, phone):
_____
_____

☐ I would like the medical provider at the SBHC to be my child's PCP

☐ My child sees a regular dentist (please list name, address, phone):
_____
_____

☐ My child does not see an outside dentist

Approximate date of last physical exam:
_____

Approximate date of last dental exam/cleaning:
_____

I consent for my child to receive xrays at the SBHC.

☐ Yes
☐ No, I would prefer decay to be diagnosed visually only
☐ N/A, I am not interested in dental services

SBHC TREATMENT:

By signing **Box 1** below you (the parent or legal guardian) grant consent for the student listed above to receive health care services from the professional staff of SCHC at the SBHC. The following services are available at the SBHC:

- Complete physical checkups (mandated physicals, sports physicals, working papers).
- First aid and assessment of acute illness, prescriptions when necessary.
- Lab tests when necessary to detect illness or infection.
- Hearing, vision, scoliosis and blood pressure screening.
- Immunizations and allergy injections (by order of an allergist).
- Dental screening, fluoride treatments, prophylaxis (cleanings), sealants, x-rays, education and counseling.
- Care for skin problems.
- Mental Health counseling.
- Health education, nutrition and weight counseling.
- Counseling for school and personal problems.
- Referral to outside agencies (specialists, counselors, etc.) for services not provided at the SBHC.

Additional services offered for teens include:

- Alcohol and substance abuse and prevention counseling, family counseling.
- Counseling regarding puberty, peer pressure, communication and responsible decision-making (in accordance with guidelines).
- Counseling options of pregnancy prevention, including abstinence and contraception, when necessary or at request of parent or guardian.

You understand that every effort will be made to contact you prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment for certain services, including advice regarding alcohol/substance abuse, mental health counseling and reproductive health. SBHC staff consider parental involvement very important and will encourage every student to involve their parent(s)/legal guardian(s) in all counseling and health care decisions.

RELEASE OF INFORMATION:

By signing below, you give us permission to use and disclose health information as necessary for treatment, payment, and our healthcare (i.e. business) operations. This may include reports to and from other health care providers in the community who may have a treatment relationship with your child. This also includes permission for us to release information to your health insurance company as necessary for processing claims. If you have insurance, services will be billed to your insurance carrier.

Syracuse Community Health Center's Notice of Privacy Practices describes how medical information of our patients may be used or disclosed and how patients can access this information. A copy of this Notice is available at the SBHC and the following website: https://www.schcny.com/wp-content/uploads/2019/10/SCHC-Notice-of-Privacy-Practices_2017-Update.pdf. By signing Box 1 below, you acknowledge you have received a copy or been shown a copy of our *Notice of Privacy Practices*.

Patient Name: _____

Box 1: CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES
I give my consent for the student listed above to receive health care services provided by Syracuse Community Health Center professional staff at the SBHC. I understand this consent also applies to releases of information described above. This consent will remain in effect until my student is no longer registered as a student of the Syracuse City School District or until such consent is withdrawn in writing. This consent may be revoked at any time. NOTE: Parental consent is not required for students who are 18 years of age or older, or for students who are parents or legally emancipated. By law, parental consent is not required for prenatal care; services related to sexual behavior; mental health care; pregnancy prevention, and the provision of services where the health of the student appears to be endangered. X_____ _____ _____ Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date (or student if 18 years or older or otherwise permitted by law)
Box 2: HEALTH INFORMATION EXCHANGE CONSENT
You may choose whether or not to allow Syracuse Community Health Center providers at the SBHC to obtain access to your child's medical records through **HealtheConnections** (or any successor), a Health Information Exchange. **HealtheConnections** is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State law. If you give consent, your child's medical records from different places where they receive health care can be accessed using a statewide computer network. Additional information about **HealtheConnections** is available at their website, https://www.healtheconnections.org/. **The choice you make on this form will NOT affect your child's ability to get medical care. The choice you make on this form does NOT allow health insurers to have access health information for the purpose of deciding whether to provide health insurance coverage or to pay my medical bills.** You may change your decision at any time by completing a new consent form. Please check ONE box below to notify us of your choice: ☐ I GIVE CONSENT for SCHC to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care). ☐ I DENY CONSENT for SCHC to access my electronic health information through HealtheConnections for any purpose, *even in a medical emergency.* X_____ _____ _____ Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date (or student if 18 years or older or otherwise permitted by law)

FOR OFFICE USE ONLY:

Received by:_____ Date: _____