SCHOOL-BASED HEALTH PROGRAM HEALTH QUESTIONNAIRE

Form must be completed and signed every year.

Patient Information

Student's Last Name: ______________________________Student's First Name: ___________________________________

Today's Date: ______________ Student's Grade: _______ Student's Teacher: __________________________________

Student's Social Security Number: _____-____-_______ Student's Date of Birth: __ / ___ / _____ Gender: Male Female

Home Address: ____

Primary Phone Number: ________________________ Name of Parent/ Legal Guardian: _________________________

Parent/Legal Guardian Date of Birth: ____ / ____ / ______ Relationship to Student: _____________________________

Can we text you with routine reminders? ◻ Yes ◻ No Number To Receive Text Messages: _______________________

Student's Race *you may choose more than one race: Asian White Black/African American
Native Hawaiian American Indian/Alaska Native Other Pacific Islander

Student's Ethnicity: Hispanic/Latino Not Hispanic/Latino **Language Spoken:** __________________________

Insurance Information

Insurance: ☐ Medicaid ☐ Commerical ☐ Medicare ☐ Uninsured Medical Insurance Company: _____________

Cardholder Name: ____________________________ Policy Number: ________________________ Group: __________

Secondary Insurance: ☐ Yes ☐ No If Yes, Policy Number: ____

Student's Primary Doctor Name: ________________________ Primary Doctor Phone Number: ______________________

Date of Student's Last Physical: ________________ ☐ I've included a copy of my child's most recent physical

Name of Student's Pharmacy: __________________ Pharmacy Address: ____

Name of Student's Dentist: _____________________________ Date of Last Dental Appointment: ___________________

Emergency Contact Information

We require the name, address and phone number of 2 contacts who can be called if you are unavailable.

Name of Contact : ____ Phone and/or Cell: __________________________

Alternate Number: ____ Relationship to Student: _____________

Name of Contact: ____ Phone and/or Cell: ___________________________

Alternate Number: ____ Relationship to Student: _____________

WHITNEY YOUNG HEALTH

Medical Information

Please list any medication that your child takes on a regular basis. (pills, sprays, inhalers, etc.).

Medication	Dosage	When do they take it	Why do they take it

Is your child taking a multivitamin: □ Yes □ No Is your child taking a fluoride supplement? □ Yes □ No

Does your child have ANY allergies: □ Yes □ No
If yes, please list and explain reaction: ____

Has your child ever been diagnosed with ANY of the following conditions: □ Asthma □ Diabetes □ ADHD

Does your child have ANY serious illness or medical conditions? □ Yes □ No
If yes, please explain and provide most recent date: ___________________________________

Has your child have ANY serious injuries or accidents? □ Yes □ No
If yes, please explain and provide most recent date: ___________________________________

Has your child have ANY surgery? □ Yes □ No
If yes, please explain and provide most recent date: ___________________________________

Has your child EVER been hospitalized overnight? □ Yes □ No
If yes, please explain and provide most recent date: ___________________________________

Does anyone in your family smoke? □ Yes □ No If yes, where: □ Inside □ Outside

Are there any health, social, or academic concerns for your child that you would like to make us aware of? □ Yes □ No

If yes, please explain: ____

** AS A REMINDER, YOU WILL NOT BE BILLED FOR ANY SERVICES THAT YOUR CHILD RECEIVES AT WHITNEY M. YOUNG, JR. HEALTH CENTER SCHOOL-BASED HEALTH CENTER. The SBHC will bill the student's health insurance for services provided on site at the SBHC. However, services received outside the SBHC (such as lab work) are subject to fees. **

The staff of the School-Based Health Center considers parental/guardian involvement essential in keeping children healthy and will encourage each student to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time.

Parent/Guardian Signature: ______________________________ **Name:** _________________________

Relationship to Student: ___________________________ Date: ______________________

SCHOOL-BASED HEALTH PROGRAM CONSENT FOR HEALTH SERVICES

The following services will be provided to your child at the School-Based Health Center (SBHC):

1) Comprehensive physical exams, including those for school sports
2) Lab tests and screenings when necessary, to detect illness or infection (i.e., strep throat)
3) Age-appropriate immunizations
4) Assessment and treatment for acute and chronic conditions, minor injuries and emergency care
5) Health and nutrition education and counseling
6) Prescriptions and medication administration
7) Referrals to mental health services
8) Oral Health screening and fluoride varnish at participating SBHC sites
9) Referrals to outside specialists, in collaboration with PCP, for services not provided at the SBHC

I hereby give consent in my absence for **MY CHILD**, ______________________________, to receive health care services including, but not limited to any age-appropriate care provided by the professional staff of the School-Based Health Center (SBHC).

- I further give consent to the staff of the SBHC to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare providers to share information regarding my child's treatment and you may exchange medical information as needed with the school nurse for coordination of care purposes.
- I further give consent to the staff of the SBHC to obtain copies of my child's most recent physical exam and immunization records from their Primary Care Provider.
- I further consent to the staff of the SBHC to obtain my child's medication history from external sources to be better informed about potential medication issues and use that information to improve safety and quality of care.
- I hereby give consent for my child to receive a Comprehensive Physical Exam by the professional staff of the SBHC.
- I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier for services rendered by Whitney M. Young, Jr. Health Center/SBHC Program.
- I understand and accept responsibility for costs associated with services provided outside of SBHC Program.
- I understand that when necessary every effort will be made to contact me 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 or advice about drug abuse, alcoholism, sexually transmitted disease, and reproductive health or outpatient mental health services.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms I have received a copy of Whitney M. Young, Jr. Health Center Privacy Practices, as well as the Patient Bill of Rights and Patient Responsibilities.

The staff of the School-Based Health Center considers parental/guardian involvement essential to keeping children healthy and will encourage each student to involve their parents/guardian in health care decisions. We encourage parents/guardian to visit or call the School-Based Health Center at any time.

Signature: ____ **Name:** ___________________________

Relationship to Student: ______________________________ Date: _______________

*****THIS FORM MUST BE SIGNED FOR CHILDREN TO ENROLL IN PROGRAM. STUDENTS OF REQUIRED LEGAL AGE MAY CONSENT DIRECTLY IN ACCORDANCE WITH LAW.
SIGNED FORMS ARE VALID AS LONG AS STUDENT REMAINS ENROLLED IN SCHOOL WITH WHITNEY YOUNG SCHOOL-BASED HEALTH CLINIC ON SITE*****

Hixny Electronic Data Access Consent Form

Whitney M. Young, Jr. Health Center

In this Consent Form, you can choose whether to allow Whitney M. Young Jr. Health Center to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Whitney M. Young Jr. Health Services to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Whitney M. Young Jr. Health Center's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Whitney M. Young Jr. Health Center may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.

You have two choices:

☐ **I GIVE CONSENT for Whitney M. Young Jr. Health Center to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for Whitney M. Young Jr. Health Center to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

____ ______________ _________________

Print Name of Patient | Date of Birth | Date

____ _________________________________

Signature of Patient or Patient's Legal Representative | Print Name of Legal Representative (if applicable)

____

Relationship of Legal Representative to Patient (if applicable)

WHITNEY YOUNG HEALTH — HEALTHCARE DESIGNED AROUND YOU

Details About Patient Information in Hixny and the Consent Process

How Your Information Will Be Used:
Your electronic health information will be used by Whitney M. Young Jr. Health Center only to:

- Provide you with medical treatment and related services.
- Check whether you have health insurance and what it covers.
- Evaluate and improve the quality of medical care.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give your health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included:
If you give consent, Whitney M. Young Jr. Health Center may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

NOTE: If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.

Where Health Information About You Comes From:
Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent:
Only these people may access information about you: doctors and other health care providers who serve on Whitney M. Young Jr. Health Services's medical staff who are involved in your medical care; health care providers who are covering or on call for Whitney M. Young Jr. Health Services's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information:
There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Whitney M. Young Jr. Health Center at: (518) 465-4771; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information:
Any electronic health information about you may be re-disclosed by Whitney M. Young Jr. Health Center to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period:
This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent:
You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Whitney M. Young Jr. Health Center. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form: You are entitled to get a copy of this Consent Form after you sign it**.**

WHITNEY YOUNG HEALTH
HEALTHCARE DESIGNED AROUND YOU

We Welcome Your Child to Our School-Based Health Center!

☺ Please fill out the attached consent form and health questionnaire to enroll your child.

☺ You are always welcome and encouraged to attend appointments with your child.

☺ Your child can receive immunizations required for school here.

☺ Your child can use the SBHC for urgent care when they are sick.

☺ Your child can receive a physical with us *or* you can provide one from another doctor.

☺ Your child can have a primary doctor that is not from Whitney M. Young, Jr. Health Center and still enroll in SBHC.

☺ We can help manage your child's health conditions such as asthma.

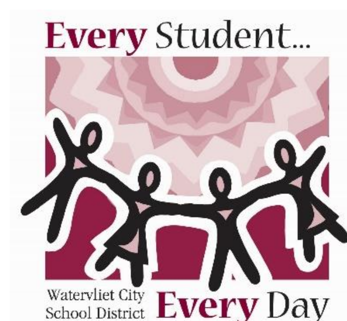
☺ We work with the school nurse; we do not replace them.

☺ There is never an out-of-pocket cost for SBHC services.

☺ Your child is enrolled as long as they attend this school or you choose to dis-enroll them.

☺ You have 24 hour access always. If school is not in session call Whitney M. Young, Jr. Health Center at 518-465-4771.

Please call your SBHC with any questions. We look forward to a great school year!
To contact the Watervliet School-Based Health Center office, please call 518-629-3270.



WHITNEY YOUNG HEALTH

PATIENT BILL OF RIGHTS

As a patient in a Clinic in New York State, you have the right, consistent with the law, to:

1. Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
2. Be treated with consideration, respect and dignity including privacy in treatment;
3. Be informed of the services available at the center;
4. Be informed of the provisions for off-hour emergency coverage
5. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. Receive an itemized copy of his/her account statement, upon request;
7. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;
10. Refuse to participate in experimental research;
11. Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;
12. Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Health Systems Management;
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment;
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;
15. Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information see: "Access to Your Medical Records" and "Do I Have the Right to See My Medical Records?";
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and.
17. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center

PATIENT RESPONSIBILITIES

Providing patients with the best care possible is a collaborative effort of provider and patient and family. In addition to the services, rights and privilege afforded to patients by Whitney Young Health, patients themselves are also requested to adhere to the following “patient responsibilities” to ensure the best overall health care services.

Provide Information:
- Give completed and accurate medical information to Whitney M. Young, Jr. Health Center Staff on the health questionnaire annually and when staff call for information.
- Provide any change of address or telephone number.

Participate:
- Be involved in you or your child’s care as a team member with the provider/medical assistant. Ask questions to fully understand your care. It may help to write down your questions prior to care.
- Follow treatment advice given.
- Adhere to all Whitney M. Young, Jr. Health Center rules and regulations.

Appointments and Tips:
- The laboratory services are billed separately and are NOT part of Whitney Young Health School Based Health Center or Mobile Unit. These charges cannot be put on a sliding scale fee.
- Allow your provider 7 business days to complete all forms.
- Allow your provider 3 business days for prescription refills.

Emergencies:
- For any emergency that is life threatening, e.g. chest pains, shortness of breath, uncontrolled bleeding, **CALL 911 or GO TO AN EMERGENCY ROOM IMMEDIATELY**.
- Whitney M. Young, Jr. Health Center has coverage 24 hours a day, 7 days a week including holidays at (518) 465-4771. Troy Health Center patients should call (518) 833-6900.
- If Whitney M. Young, Jr. Health Center is closed for the day, calls will be transferred to our answering exchange.
- A patient directed to an emergency facility or their designee must contact their primary care provider within 48 hours of the visit to an emergency room or admission to the hospital to coordinate follow up care.