

## MONTEFIORE SCHOOL HEALTH PROGRAM

3380 Reservoir Oval, LL

Bronx, NY 10467

Tel: 718-696-4060

Fax: 718-231-1586



### High School Health Centers

#### Bronx Regional Campus

979 Rogers Place  
Bronx, New York 10459  
Tel: 718-589-5665  
Fax: 718-589-5509

#### DeWitt Clinton High School

100 W. Mosholu Pkwy So  
Bronx, New York 10468  
Tel: 718-549-8022  
Fax: 718-549-7977

#### Evander Campus

800 East Gunhill Road  
Bronx, New York 10467  
Tel: 718-944-5601  
Fax: 718-944-5588

#### Lehman Campus

3000 East Tremont Avenue  
Bronx, NY 10461  
Tel: 718-430-6375  
Fax: 718-430-6316

#### Theodore Roosevelt Campus

500 East Fordham Road  
Bronx, New York 10458  
Tel: 718-329-1276  
Fax: 718-329-1967

#### South Bronx Campus

701 St. Anns Avenue  
Bronx, NY 10455  
Tel: 718-402-7618  
Fax: 718-993-1916

#### Walton Campus

2780 Reservoir Avenue  
Bronx, New York 10468  
Tel: 718-329-8589  
Fax: 718-562-4357

Dear Parent/Guardian:

Your child's school, in partnership with the Montefiore School Health Program, has a comprehensive health center that is different from the school nurse's office. The health center provides students with emergency care and first aid for minor injuries; physical exams for school, sports or working papers, confidential mental health counseling & stress reduction, immunizations, asthma care, and more.

**To enroll your child in the clinic, please complete the enclosed forms and provide the following:**

- Parental/Guardian Consent Form
- Medical History Form. All information is kept confidential.
- **Include a copy of your child's immunization record**
- **Include a copy of insurance information.**

### Health Center's FAQs

#### What are our hours?

We are open school days: Monday – Friday 8:00 AM to 3:30 PM. Closed daily for a half-hour lunch.

#### Who is on the staff?

Medical Provider(s), Mental Health Provider(s), Licensed Practical Nurse, Community Health Organizer and an Office Manager.

#### Does my child need to be insured?

No, we will see your child regardless of their insurance coverage.

#### Am I responsible for co-pays?

No, we bill insurance whenever possible to help cover our program costs but do not charge co-pays. Insurance is also important to facilitate any referrals to sub-specialists and for diagnostic testing.

#### Does my child need to be a US citizen?

No, your child does not need to be a US citizen. We do not collect information on citizenship status.

#### Does my child need to change their regular health care provider?

No, you may keep your regular doctor. We work with and communicate with your child's health care providers, specialists or mental health providers whether they are Montefiore or non-Montefiore providers.

We are committed to the health of the students and invite you to share your questions or concerns with us.

Sincerely,

The Montefiore School Health Program

### Elementary & Middle School Health Centers

#### P.S. 8

3010 Briggs Avenue  
Bronx, New York 10458  
Tel: 718-563-5263  
Fax: 718-295-4587

#### P.S. 28

1861 Anthony Avenue  
Bronx, New York 10457  
Tel: 718-901-2849  
Fax: 718-583-6453

#### M.S. 45

2502 Lorillard Place  
Bronx, New York 10458  
Tel: 718-584-2936  
Fax: 718-584-2936

#### P.S. 55 & Mott Hall III

450 St. Paul's Place  
Bronx, New York 10456  
Tel: 718-588-3766  
Fax: 718-538-0698

#### P.S. 85

2400 Marion Avenue  
Bronx, New York 10458  
Tel: 718-584-9615  
Fax: 718-584-5586

#### P.S./M.S. 95

3961 Hillman Avenue  
Bronx, New York 10463  
Tel: 718-796-3440  
Fax: 718-601-2357

#### P.S. 105

725 Brady Avenue  
Bronx, New York 10462  
Tel: 718-828-3235  
Fax: 718-828-3235

#### I.S. 216, 217, & Charter School

977 Fox Street  
Bronx, New York 10459  
Tel: 718-617-4449  
Fax: 718-617-4756

#### MS 142

3750 Baychester Avenue  
Bronx, NY 10466  
Tel: 718-654-5509/3949  
Fax: 718-654-9434



**NYC Department of Education School Health Program  
School Parental Consent Form**

**SCHOOL BASED HEALTH CENTER SERVICES**

I consent for my child to receive health care services provided by the State-licensed health professionals of Montefiore Medical Center 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 pupils 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 (including eye glasses), 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. Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot) among other methods], testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. 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.
8. Dental examinations including: diagnosis, treatment, and sealants where available.
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.

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

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

By signing this consent, I am authorizing medical information to be given to the Board of Education of the City of New York (a/k/a 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 medical 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 Montefiore Medical Center School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a 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:**

- |  |  |
|--|--|
| <p><b>Information Required by Law or Chancellor's Regulation:</b></p> <ul style="list-style-type: none"> <li>- New Entrant Exam (Form 211S)</li> <li>- Immunizations</li> <li>- Vision and hearing screening results</li> <li>- Tuberculin test results</li> </ul> | <p><b>Information to Protect Health and Safety:</b></p> <ul style="list-style-type: none"> <li>- Conditions which may require emergency medical treatment (Form 103S)</li> <li>- Conditions which limit a student's daily activity (Form 103S)</li> <li>- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).</li> <li>- Health insurance coverage</li> </ul> |
|--|--|

**My signature on page 1 of this form also gives my consent to Montefiore Medical Center to contact other providers that have examined my child and to obtain insurance information.**

**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



# Guidelines for Adolescent Preventive Services

## Parent/Guardian Questionnaire

**Confidential**

(Your answers will not be given out.)

Date \_\_\_\_\_

Adolescent's name \_\_\_\_\_ Adolescent's birthday \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Relationship to adolescent \_\_\_\_\_

Your phone number: Home \_\_\_\_\_ Work \_\_\_\_\_

### Adolescent Health History

1. Is your adolescent allergic to any medicines?  
 Yes  No If yes, what medicines? \_\_\_\_\_

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?  
 Yes  No If yes, give the age at time of hospitalization and describe the problem.  

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?  
 Yes  No If yes, please explain. \_\_\_\_\_

5. Have there been any changes in your adolescent's health during the past 12 months?  
 Yes  No If yes, please explain. \_\_\_\_\_

6. Please check (✓) whether your adolescent ever had any of the following health problems:  
 If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?  
 Yes  No  Not sure

### Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seiures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Stepmother            | <input type="checkbox"/> Sister(s)/ages _____ |
| <input type="checkbox"/> Mother                         | <input type="checkbox"/> Stepfather            | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Father                         | <input type="checkbox"/> Guardian              | <input type="checkbox"/> Alone                |
| <input type="checkbox"/> Other adult relative           | <input type="checkbox"/> Brother(s)/ages _____ |   |

10. In the past year, have there been any changes in your family? (Check all that apply.)

- |                                     |   |  |                                      |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Marriage   | <input type="checkbox"/> Loss of job                | <input type="checkbox"/> Births          | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to a new neighborhood | <input type="checkbox"/> Serious illness |                                      |
| <input type="checkbox"/> Divorce    | <input type="checkbox"/> A new school or college    | <input type="checkbox"/> Deaths          |                                      |

**Parental/Guardian Concerns**

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems .....	<input type="checkbox"/>	Guns/weapons .....	<input type="checkbox"/>
Physical development .....	<input type="checkbox"/>	School grades/absences/dropout .....	<input type="checkbox"/>
Weight .....	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco .....	<input type="checkbox"/>
Change of appetite .....	<input type="checkbox"/>	Drug use .....	<input type="checkbox"/>
Sleep patterns .....	<input type="checkbox"/>	Alcohol use .....	<input type="checkbox"/>
Diet/nutrition .....	<input type="checkbox"/>	Dating/parties .....	<input type="checkbox"/>
Amount of physical activity .....	<input type="checkbox"/>	Sexual behavior .....	<input type="checkbox"/>
Emotional development .....	<input type="checkbox"/>	Unprotected sex .....	<input type="checkbox"/>
Relationships with parents and family .....	<input type="checkbox"/>	HIV/AIDS .....	<input type="checkbox"/>
Choice of friends .....	<input type="checkbox"/>	Sexual transmitted diseases (STDs) .....	<input type="checkbox"/>
Self image or self worth .....	<input type="checkbox"/>	Pregnancy .....	<input type="checkbox"/>
Excessive moodiness or rebellion .....	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual) .....	<input type="checkbox"/>
Depression .....	<input type="checkbox"/>	Work or job .....	<input type="checkbox"/>
Lying, stealing, or vandalism .....	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs .....	<input type="checkbox"/>		

12. What seems to be the greatest challenge for your teen? \_\_\_\_\_

13. What is it about your teen that makes you proud of him or her? \_\_\_\_\_

14. Is there something on your mind that you would like to talk about today?

What is it? \_\_\_\_\_

15. Can we share your answers to Question 13 with your teen?  Yes  No