Hometown Health Centers

1044 State Street, Schenectady, NY 12307
(518) 370-1441 | hometownhealthcenters.org

Hometown Health Centers

SCHOOL-BASED HEALTH CENTER SERVICES - Parental Consent Form

I _____ (Print Name) certify that I am the parent or legal guardian of

_____ (Print Student Name) _____ (Student Date of Birth).

Hometown Health Centers

Hometown Health Centers (Hometown – www.HometownHealthCenters.org) is a nonprofit community health center given permission by the Federal government and State of New York to provide health services.

Consent and Authorization for Providing Care

I consent and authorize Hometown Health Centers through its school based program to provide medical and behavioral health services, if my child asks for such services. These services may include, but not be limited to: tests, referrals, screenings, examinations, evaluations, assessments, medical and behavioral health care, and education and counseling. My child will be encouraged to involve me in counseling and medical decisions.

Consent and Authorization for Release and Discussion of Information

I authorize my child's school or primary care provider to release copies of physical exams, medication histories, and immunization record to Hometown. This release includes permitting the school and primary care provider to discuss my child's healthcare directly with Hometown.

I understand that by law, parental consent is not required for prenatal care, services related to sexual behavior, mental health care 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 over 18 years or those who are parents or are emancipated.

Confidentiality and Legal Requirements

I understand that confidentiality between my child and Hometown's health provider may be required under New York State Law, though may be disclosed to third party payers for billing purposes. I understand New York State law requires certain health information be shared with the school nurse. Information not required to be shared will be done solely at the discretion of the Hometown healthcare professional caring for my child.

I understand Hometown may consult and communicate with other healthcare professionals regarding care by providing or requesting patient information about my child.

Care without Contact

I understand I'm providing consent and authorization to see my child regardless of whether I am contacted first, so long as my child has voluntarily asked for medical or behavioral health services.

Revoking Consent and Authorization

I further understand my consent and authorization for all health care services, including primary care and behavioral health, and the release and discussion of healthcare information shall remain in effect unless I provide written notice to Hometown Health Centers revoking it.

Signature: _____ Date:_____

Parent /Guardian (Print Name): _____ Home phone: ( )_____
Day time phone: ( )_____ Cell phone: ( )_____

HOMETOWN HEALTH CENTERS SCHOOL-BASED HEALTH CENTER REGISTRATION

STUDENT INFORMATION

Student's Last Name:_____
Student's First Name: _____
Student's Middle Initial: _____

Date of Birth: _____/_____/_____
Month Day Year

Student's Social Security Number: _____

Student's School: _____
Grade:_____

Sex: □ Male □ Female

Ethnicity: □ Hispanic/Latino □ Not Hispanic or latino
□ Refuse to report

Race: □ Native-Hawaiian □ Black/African American □ White
□ American Indian/Alaska Native □ Asian □ Other Race
□ Other Pacific Islander □ Unreported/Refuse to report
□ More than one race

Preferred Language: _____

Student's Address: _____
_____

_____ _____ _____
City State Zip Code

☐ Homeless

INSURANCE INFORMATION

Does the child have health insurance? □ No □ Yes

Name of Health Insurance Company:

_____
Insurance ID #: _____
Group #: _____

Policy Holder: _____

Relationship to patient: _____

Policy Holder's Date of Birth:_____/_____/_____ Sex: F ____ M ____
Mo. Day Year

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, If Applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student
□ Grandparent □ Aunt or Uncle □ Other: _____

Contact Information for parent or guardian

Home Tel: ( )_____
Work Tel: ( ) _____
Cell: ( )_____
email address: _____

☐ **Please register me for Hometown Health's Patient Portal with the provided email address above.**

I give my permission for HHC to contact me via (select all that apply):

☐ Phone / voice mail ☐ Text ☐ Email

Who is the student's regular doctor? ☐ **Hometown Health Dr.**

Name: _____

Telephone: _____

Address: _____

*Pharmacy – all prescriptions will be transmitted to College Hometown Pharmacy at Hometown Health Centers, 1044 State Street, Schenectady, unless otherwise identified below.

Pharmacy Name: _____

Pharmacy Telephone # : _____

If your child does not have health insurance, would you like to be contacted by a Hometown Health Centers Enrollment Specialist who can assist you with obtaining free or low-cost health insurance? □ No □ Yes	**HOMETOWN HEALTH ADMINISTRATIVE USE** HHC Staff Name: _____ HHC Staff Signature: _____ Date Completed: _____/_____/_____ Mo. Day Year