



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

## Hometown Health Centers, Schenectady

# Confidential Services School-Based Health Center Consent Form

I consent to receive health care services in one of the Schenectady School District’s eligible schools (Schenectady High School, Mont Pleasant/Hamilton Elementary) school-based health center (SBHC). Physicians and Nurse Practitioners employed by Hometown Health Centers staff the SBHC program which is licensed by the New York State Department of Health. Confidential Services provided by the SBHC may include:

- Reproductive health care services, including abstinence counseling, contraception, testing for pregnancy, STD screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate.
- 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.

I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and the students will be encouraged to involve their parents or guardians in counseling and medical care decisions.

I authorize Hometown Health Centers to release information regarding treatment to third party payers or others for purposes of billing and for any reason that may be required to comply with statutes or regulations in accordance with accepted medical practices.

I have read the above information and have had the opportunity to have any of my questions answered. I understand that this consent form will be in for Confidential Services only.

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 who are 18 years or older or for students who are parents or legally emancipated.

For more information about Youth and Student Rights, visit the New York Civil Liberties Union NYCLU website: <http://www.nyclu.org/issues/youth-and-student-rights>

X \_\_\_\_\_  
Signature of Student

Date \_\_\_\_\_

*(please print)*

Student Name: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_

Day time phone: ( ) \_\_\_\_\_

Cell phone: ( ) \_\_\_\_\_

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## HOMETOWN HEALTH CENTERS SCHOOL-BASED HEALTH CENTER REGISTRATION

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p><b>Student's Last Name:</b> _____</p> <p><b>Student's First Name:</b> _____</p> <p><b>Student's Middle Initial:</b> _____</p> <p><b>Date of Birth:</b>    _____/_____/_____</p> <p style="padding-left: 40px;">Month                  Day                  Year</p> <p><b>Student's Social Security Number:</b> _____</p> <p><b>Student's School:</b> _____</p> <p><b>Grade:</b> _____</p> <p><b>Sex:</b>   <input type="checkbox"/> Male    <input type="checkbox"/> Female</p> <p><b>Ethnicity:</b>   <input type="checkbox"/> Hispanic/Latino   <input type="checkbox"/> Not Hispanic or latino  <input type="checkbox"/> Refuse to report</p> <p><b>Race:</b>   <input type="checkbox"/> Native-Hawaiian   <input type="checkbox"/> Black/African American   <input type="checkbox"/> White  <input type="checkbox"/> American Indian/Alaska Native   <input type="checkbox"/> Asian   <input type="checkbox"/> Other Race  <input type="checkbox"/> Other Pacific Islander   <input type="checkbox"/> Unreported/Refuse to report  <input type="checkbox"/> More than one race</p> <p><b>Preferred Language:</b> _____</p> <p><b>Student's Address:</b> _____</p> <p>_____</p> <p>_____</p> <p>City    State                          Zip Code</p> <p><input type="checkbox"/> Homeless</p>	<p><b><u>Mother</u></b>  Last Name: _____ First Name: _____</p> <p><b><u>Father</u></b>  Last Name: _____ First Name: _____</p> <p><b><u>Legal Guardian, If Applicable</u></b>  Last Name: _____ First Name: _____</p> <p><b><u>Relationship of legal guardian to student</u></b>  <input type="checkbox"/> Grandparent   <input type="checkbox"/> Aunt or Uncle   <input type="checkbox"/> Other: _____</p> <p><b><u>Contact Information for parent or guardian</u></b>  Home Tel: (    ) _____  Work Tel: (    ) _____  Cell: (    ) _____  email address: _____</p> <p><b>May we contact you via (select all that apply):</b></p> <p style="text-align: center;"><input type="checkbox"/> Phone / voice mail   <input type="checkbox"/> Text   <input type="checkbox"/> Email</p> <p><b>Who is the student's regular doctor?   <input type="checkbox"/> Hometown Health Dr.</b></p> <p>Name: _____</p> <p>Telephone: _____</p> <p>Address: _____</p> <p><small>*Pharmacy – all prescriptions will be transmitted to College Hometown Pharmacy at Hometown Health Centers, 1044 State Street, Schenectady, unless otherwise identified below.</small></p> <p>Pharmacy Name: _____</p> <p>Pharmacy Telephone # : _____</p>
<p style="text-align: center;"><b>INSURANCE INFORMATION</b></p> <p><b>Does the child have health insurance?</b>   <input type="checkbox"/> No           <input type="checkbox"/> Yes</p> <p><b>Name of Health Insurance Company:</b> _____</p> <p>Insurance ID #: _____</p> <p>Group #: _____</p> <p>Policy Holder: _____</p> <p>Relationship to patient: _____</p> <p>Policy Holder's Date of Birth: ____/____/____ Sex: F ____ M ____</p> <p style="padding-left: 40px;">Mo.   Day   Year</p> <p>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?   <input type="checkbox"/> No           <input type="checkbox"/> Yes</p>	<p style="text-align: center;"><b>HOMETOWN HEALTH ADMINISTRATIVE USE</b></p> <p>HHC Staff Name: _____</p> <p>HHC Staff Signature: _____</p> <p>Date Completed: ____/____/____</p> <p style="text-align: center;">Mo.   Day   Year</p>