



## 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](http://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	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> _____/_____/_____  <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div></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>City _____ State _____ Zip Code _____</p> <p><input type="checkbox"/> Homeless</p>	<p><b>Mother</b>  Last Name: _____ First Name: _____</p> <p><b>Father</b>  Last Name: _____ First Name: _____</p> <p><b>Legal Guardian, If Applicable</b>  Last Name: _____ First Name: _____</p> <p><b>Relationship of legal guardian to student</b>  <input type="checkbox"/> Grandparent    <input type="checkbox"/> Aunt or Uncle    <input type="checkbox"/> Other: _____</p> <p><b>Contact Information for parent or guardian</b>  Home Tel: (    ) _____  Work Tel: (    ) _____  Cell: (    ) _____  email address: _____</p> <p style="text-align: center;"><input type="checkbox"/> <b>Please register me for Hometown Health's Patient Portal with the provided email address above.</b></p> <p><b>I give my permission for HHC to contact me 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?</b>    <input type="checkbox"/> Hometown Health Dr.</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="text-align: center; font-size: small;">Mo.    Day    Year</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?    No       Yes

**HOMETOWN HEALTH ADMINISTRATIVE USE**

HHC Staff Name: \_\_\_\_\_

HHC Staff Signature: \_\_\_\_\_

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo.   Day   Year