Montefiore School Health Program

School Based Health Center

Student Self - Consent for Reproductive Health Services Only

Source
___In-classroom presentation
___Orientation/Bridge Prog.
School-wide programs
___Student engagement

For office use only

OSIS# ________________________________ ***Medical Record # (MRN)***________________________

Please know that you can use the School-Based Health Center and see your other doctors.
Signing this consent <u>does not</u> change your insurance, <u>does not</u> change your private doctor, and <u>does not</u> affect the Number of times you can see your private doctor.

STUDENT INFORMATION

Student Last Name: ___________________________________

Student First Name: __________________________________

Date of Birth: __________/__________/___________
Month Day Year

Sex: ❑ Male ❑ Female **Grade**:_____________

Student Address:_____________________________________
____
City State Zip Code

Student email :__________________________________

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____________

❑ Male ❑ Female Grade _____________

***Student Social Security Number:** ____________________

(*optional field: Used for insurance purposes only)

Do you have a regular doctor? □ No □Yes, please list here
OK to contact MD? ☐No ☐ Yes
Name: ____
Telephone: ____
Address: ____

EMERGENCY CONTACT INFORMATION ONLY

<u>Parent / Legal Guardian:</u>
Last Name: __________________ First Name: _______________
Home/Work Tel: ____
Cell Phone: ____
Email: ____

If legal guardian , relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑Other: ________

Preferred Language of Parent/ Guardian:__________________

ADDITIONAL EMERGENCY CONTACT

Last Name:___________________ First Name:________________
Relationship to Student: ___________________________________
Home or Work Tel:____
Cell: ____

Indicate the Pharmacy where we can send prescriptions
Pharmacy Name___________________________________
Pharmacy Address: ________________________________
Pharmacy Tel: ____________________________________

INSURANCE INFORMATION

Do you have Medicaid OR Child Health Plus? ❑ No ❑ Yes

Medicaid ID # __________________________ CHP # _______________________________

REPRODUCTIVE HEALTH SERVICES

1. Comprehensive Physical Exams as it relates to reproductive health care.
2. HIV testing (using an oral specimen with rapid results) for males and females
3. Screening and treatment for sexually transmitted infections for males and females.
4. Pregnancy prevention (including all methods of birth control.)
5. Emergency contraception
6. Pregnancy Testing
7. Referrals for reproductive health services not provided at the school-based health center.
8. HPV Vaccine: Patient must be provided with the Vaccine Information Sheet (VIS) and agree to be immunized
9. Options counseling for newly diagnosed pregnancy, referral for prenatal care or for pregnancy termination

STUDENT CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

The School Based Health Center has explained to me the scope of the Reproductive Health Services that I may receive.
I have read and understand the services listed above and my signature provides consent to receive confidential reproductive health services provided by Montefiore Medical Center's School-Based Health Center.

My signature acknowledges that I have been provided a copy of the Notice of Privacy Practices.

____ ______________________
Signature of Student **Date**

Montefiore School Health Program

School Based Health Center

REPRO Student Basic Health History

Name	DOB (Mo/Day/Year)	Grade	School

Dear Student: Your health is important to us. Each year we conduct a Brief Health Assessment on every child enrolled in the Montefiore School-Based Health Center to understand his or her health care needs. This includes checking height, weight, and blood pressure. We also review the vaccine record. This does not replace the full physical exam that you should get every year with their usual health care provider. Please include the name of your health care provider so we may work together in your care.

If you do not have a health care provider, we can do the full physical exam at the school health center. Insurance is not required. We are part of Montefiore Medical Center, and use the same medical record as the Montefiore Health System. This means we can communicate directly with Montefiore doctors through your medical record. Please let us know if your contact information changes. To help the School Health team understand your health needs for ongoing care and in case of emergency, please answer the following questions.

Have you had any serious or chronic health problems?	**No**	**Yes**
Asthma		
Depression or Anxiety *(circle one or both, if yes)*		
Overweight or Obesity		
Other Chronic Conditions (Diabetes, Sickle Cell, etc.)		
Were you ever diagnosed with a heart murmur?		
Do you take any medications regularly? **If yes, please list the name, dose and how often it is taken.**		
Have you ever been hospitalized or had surgery? **If yes, for what?**		
Have you ever had chicken pox disease? **If Yes, Age______**		
Allergies to medications or food?	**No**	**Yes**
Are you allergic to any medications? **If yes, please list**		
Are you allergic to any foods? **If yes, please list:**		
If yes, do you have an Epi-pen?		

Have any family members had any of the following problems? Check all that apply.	**Mother**	**Father**	**Sibling**	**Grand parent**	**Other**
Asthma					
Diabetes					
Heart attack or stroke before age 45 years					
High Cholesterol					
Smoking tobacco cigarettes/cigars					
Other:					
Other:					
Deceased					
Other:					

The NYS Department of Health requires us to ask the following questions about risk for tuberculosis and risk for lead poisoning.	**No**	**Yes**
Have you ever had tuberculosis or a positive skin test for tuberculosis? **If Yes, Age________Yr. _______**		
Have you been exposed to anyone with tuberculosis (TB) disease? If Yes, When______________ Who ________________		
Have you had close contact or live with a person who has a positive TB skin test? **If Yes, When? __________________________**		
Have you lived in the United States for less than 5 years? **If Yes, where?**		
Have you traveled outside the US for more than one month? **If Yes, Age ________ Where? __________________________**		
Have you traveled to, or used products (glazed pottery, folk remedies, cosmetics, foods, or spices) imported from Haiti, Mexico, Dominican Republic, Pakistan, Bangladesh?		

Date (Mo/Day/Year)	*Name*	*Signature*