Hometown Health Centers

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 _____ Date_____

Signature of Student

*(please print)*

Student Name: _____ Home phone: ( )_____

Day time phone: ( )_____ Cell phone: ( )_____

# Confidential Services School-Based Health Center Consent Form

## 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

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

### 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: _____

**May we contact you 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 # : _____

### HOMETOWN HEALTH ADMINISTRATIVE USE

HHC Staff Name: _____

HHC Staff Signature: _____

Date Completed: _____/_____/_____
Mo. Day Year