Family Health Network of CNY, Inc.
School Health Program – Cincinnatus
2809 Cincinnatus Road, Cincinnatus, NY 13040
(607) 863-3200 x2 x2

The **School Health Program** is an all-inclusive pediatric office staffed by a Physician Assistant and Aide on-site in Cincinnatus Central School.
Services include:

- treatment of acute illness/injury
- monitoring of chronic illness
- physical exams
- immunizations
- behavioral health medication management

Our services are available at no out-of-pocket costs to all students in Cincinnatus Central School grades Pre-K through 12th. However, students must be enrolled in the School Health Program to receive our services. If you wish to enroll your child, please complete and return the enrollment packet to the School Health Program.

For a child to be seen, a parent or legal guardian **must** notify us by calling the office or sending in a note with the child.
Please specify:

- the reason the child needs to be seen
- any symptoms the child is having
- how long the symptoms have been occurring
- all medications the child is taking
- the best way to reach you by telephone

If your child is home ill, you may also call for an appointment to bring your child in to the School Health office.

- **Provider is available on Mondays, Wednesdays and Thursdays**
- Office is open 8:00 a.m. – 3:30 p.m. on Monday, Wednesday, Thursday & Friday
- Closed on Tuesdays and during school breaks

Thank you for supporting our program.

Cincinnatus School Health Program Staff

Jeannine Dodds RPA-C
Nicole Villapiano MD
Caryl Warner, School Health Program Aide

Family Health Network of Central New York, Inc

FAMILY HEALTH NETWORK OF CNY-SCHOOL HEALTH PROGRAM * INSURANCE/DATA FORM

Student name_____ SSN: _____ Date of Birth_____

Address_____ City/Town_____ Zip Code_____

Home Telephone # (_____) _____ Alternate Telephone (e.g. cell) # (_____) _____

Emergency Contact Person _____ Contact's Telephone # (_____) _____

Emergency contact's relationship to student _____

Does student have any allergies? ☐ Yes ☐ No If yes, to what? _____

Allergic reaction (hives, itching, swelling, etc.) _____

Who is the student's designated Primary Care Provider? _____Telephone # (_____) _____

Address _____

This question is strictly confidential and is asked for statistical reporting ONLY:
Student's Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Native American ☐ Other_____

INSURANCE INFORMATION – PLEASE COMPLETE BOTH PARTS

PART 1 - IF THE STUDENT HAS MEDICAID, PLEASE COMPLETE THIS SECTION

Identification number from card (i.e.: AB12345C) _____

Does the student have other medical insurance coverage? ☐ YES ☐ NO (If yes, please complete the insurance section below)

INSURANCE INFORMATION – PART 2

Does the student have health insurance coverage? ☐ YES ☐ NO

If yes, name and address of insurance carrier: _____

Insured's ID# _____ Group # _____

Insured's Name (person carrying coverage) _____ Relationship to Student_____

Insured's Date of Birth_____ Insured's Employer _____

Insured's Address (if different from student)_____ City_____ State_____ Zip_____

Complete this section ONLY if there is a Secondary Insurance

Secondary Insurance Information:

Is this student covered by another insurance? ☐ YES ☐ NO If yes, name of insurance _____

Billing address of company_____

Insured's ID# _____ Group # _____

Insured's Name (person carrying coverage) _____ Relationship to Student_____

Insured's Date of Birth_____ Insured's Employer _____

Insured's Address (if different from student)_____ City_____ State_____ Zip_____

Do you have a plan that pays for all or part of prescription medication(s)? ☐ YES ☐ NO

Please complete reverse side

If your child does not have health insurance coverage, he/she may be eligible for **CHILD HEALTH PLUS**. This program is available regardless of income to all children under 19 years of age. This program may be beneficial to your family. Would you like to receive more information regarding this invaluable program? ☐ YES ☐ NO

If your family does not have health insurance, we can provide assistance with enrolling you in health insurance through the Health Exchange. Would you like information on the Health Exchange? ☐ Yes ☐ No

PLEASE READ AND SIGN:
I authorize the release of any medical information necessary to process billing to the designated insurance carrier and made payable to FAMILY HEALTH NETWORK OF CNY, INC.

SIGNATURE	RELATIONSHIP TO STUDENT	DATE

PLEASE NOTE: If your insurance company remits payment directly to you for services, it is your responsibility to forward this payment to FAMILY HEALTH NETWORK OF CNY, INC., 85 South West Street, Homer, NY 13077. Failure to remit this payment is insurance fraud.

Family Health Network of Central New York, Inc.

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SSN# _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize Family Health Network of CNY to release information from my medical record as indicated below to:

TO:	**FROM:**
NAME: _____	NAME: Family Health Network.
ADDRESS: _____	ADDRESS: _____
CITY: _____ STATE: NY ZIP: _____	CITY: _____ STATE: ____ ZIP: _____
PHONE: _____ FAX: _____	PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:		DATES
☐ History and physical exam	_____	☐ X-ray reports	_____
☐ Progress notes	_____	☐ Other	_____
☐ Lab reports	_____		_____

I hereby authorize _____ to release information from my medical record as indicated below to:

TO:	**FROM:**
NAME: Family Health Network	NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ STATE: NY ZIP: _____	CITY: _____ STATE: ____ ZIP: _____
PHONE: _____ FAX: _____	PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:		DATES
☐ History and physical exam	_____	☐ X-ray reports	_____
☐ Progress notes	_____	☐ Other	_____
☐ Lab reports	_____		_____

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

- **This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder except as provided at §§2.12(c)(5) and 2.65.**

☐ Mental health (including psychotherapy notes)

☐ HIV-related information (AIDS related testing)

- **This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not, except in limited circumstances set forth in this part, sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both.**

X _____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE

(CONSENT FOR INFORMATION, WITHIN THIS BOX ONLY, EXPIRES ONE YEAR AFTER THE DATE WRITTEN ABOVE)

Revised: 05/24/10; 07/11/12; 11/20/12; 11/21/13; 02/22/2016, 02/2018

Family Health Network of Central New York, Inc.

Authorization for Release of Information

PURPOSE OF RELEASE: ☐ Changing physicians ☐ Consultation/second opinion ☐ Legal ☐ School
☐ Continuity of care between FHN School Health Program and Primary Care Provider
☐ Other (please specify): _____

1. I understand that this authorization will expire upon discharge from the School Health Program after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that I am being requested to sign this reciprocal release by Family Health Network of CNY for the purpose of continuity of care between the School Health Program and my primary care provider.
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   a. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

5. I understand that in compliance with New York State statute, I will pay a fee of $ .75 per page. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

For records not being sent to another medical provider, please complete questions 6 and 7 below.

6. I wish to receive ☐ a hard copy ☐ an electronic copy

7. I wish to have the record delivered:
   ☐ Will be picked up at the health center ☐ by me ☐ by _____
   Name of individual authorized to pick up records
   ☐ Mailed to the following address: _____
   ☐ Email to the following email address: _____
   I understand that if I request the record be emailed, it will not be encrypted and there is a risk that my Protected Health Information could be read or accessed by a third party while in transit.

_____ _____
SIGNATURE OF PATIENT DATE

_____
PRINTED NAME OF PATIENT

OR

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____
PRINTED NAME OF PARENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
RECORDS RECEIVED BY DATE

Revised: 05/24/10; 07/11/12; 11/20/12; 11/21/13; 02/22/2016, 02/2018

Family Health Network of Central New York, Inc.

SCHOOL HEALTH PROGRAM

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I _____ understand that as part of my health care, Family Health Network of CNY, Inc. (FHN) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information may be used and disclosed as:

- A basis for planning my care and treatment;
- A means of communication among the many healthcare professionals who contribute to my care, inclusive of designated school personnel;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer, my insurance company, can verify that the services billed were actually provided; and/or
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided the "*HIPAA Notice of Privacy Practices*" that provides a more complete description of information uses and disclosures.

I understand that I may revoke this consent, in writing, at any time except to the extent that FHN has already taken action in reliance thereon. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I further understand that FHN is not required to agree to the restrictions requested. I also understand that by refusing to sign, restricting, or revoking this consent, Family Health Network may refuse to treat me. If I choose to restrict or revoke this consent, I understand it will be effective the date the written request is received by FHN and that no further services will be provided. I also understand that if my restriction/revocation in any way affects insurance reimbursement for services already received, I will be billed for any outstanding amount.

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law including disclosure via electronic means.

I hereby consent and authorize Family Health Network to provide or prescribe care, treatment, injections, immunizations, laboratory tests, x-rays, procedures, and/or medications to me per policy and/or as prescribed by my health care provider. I understand that the treatment plan may change, and if so, these changes will be discussed with me. I agree to notify my physician, dentist, or others providing care of any adverse reactions or other significant events relating to my health.

I ☐ **have** ☐ **have not** selected to use the back of this form to outline ☐ **restrictions** ☐ **permissions**

I fully understand and ☐ **accept** ☐ **decline** the terms of this consent.

_____ _____

Signature of Patient, Parent, Legal Representative/Guardian, or Power of Attorney (please circle one) — Date of Signature

_____ _____

Signature of Witness **(witness MUST be over 18 years of age)** — Date of Signature

Restrictions

I wish to have the following restrictions placed on the use and/or disclosure of my health information:

_____

_____

_____

_____

_____

_____

Permissions:

Family Health Network may discuss my protected health information, treatment, payment or healthcare operations with the following persons (*please check all that apply)*

☐ Spouse ☐ Parents ☐ Relatives ☐ Others

Please list the names and relationship:

_____

_____

_____

_____

_____

Messages or Appointment Reminders *(check all that apply)*

Family Health Network ☐ may ☐ may **not** leave messages.

Messages or appointment reminders using your provider's/practice's name can be left:

☐ at my home ☐at my work ☐ on my answering machine ☐ with someone

☐ on my cell phone #_____

Messages will be of a non-sensitive nature such as appointment reminders.

FOR OFFICE USE ONLY

☐ Parent/patient refused to sign the consent form and was referred to the Provider for evaluation and discussion. Provider:

- ☐ Completed the Consent Variation Form
- ☐ Refused to treat the individual
- ☐ After discussion, parent/patient completed the standard consent form

☐ Restrictions were added by the patient (see restrictions listed above).

☐ Consent received and reviewed by *(name)* _____ on *(date)* _____

☐ Consent placed in the patient's medical record on *(date)* _____

Family Health Network of CNY – School Health Program
Child Health Record - Initial History

Your son's/daughter's health is important to us. In order for us to have a better understanding of his/her past and present medical history, we request that you complete the following questionnaire. Thank you for your time and cooperation.

Date _____ **Student's Name** _____ ☐ Male ☐ Female

Date of Birth _____ **SS#** _____

I. Pregnancy/Birth History

1. Was this child born: ☐ Vaginally ☐ Emergency C-Section ☐ Repeat C-Section
2. Was this child premature? ☐No ☐ Yes how many weeks premature?_____
3. Birth weight _____Length _____Apgar (if known) _____
4. Any problems at birth with this child (jaundice, heart murmur, respiratory distress, etc) ? ☐No ☐ Yes – please describe_____
5. Was your baby in the NICU? ☐No ☐ Yes How many days and why?_____

II. Feeding/Dietary

1. Does this child have any food sensitivities or food allergies (dairy, gluten, etc)? ☐ No ☐ Yes - Please list to what and reaction:

   _____
2. Is this child on a special diet? ☐ No ☐ Yes – Please describe _____
3. Is this child a picky eater? ☐ No ☐ Yes – Please describe _____

III. Growth/ Development

1. Does this child have any problems with or do you have concerns about:
   a. Sleeping habits (nightmares, night terrors, etc) ☐ No ☐ Yes (if Yes explain)

      _____
   b. Eating ☐ No ☐ Yes (explain) _____
   c. Weight gain or weight loss ☐ No ☐ Yes (explain)

      _____
   d. Growth (height) ☐ No ☐ Yes (explain)

      _____
   e. Getting along with other children ☐ No ☐ Yes (explain)

      _____
   f. School performance ☐ No ☐ Yes (explain)

      _____
   g. Behavior (lack of control, overactive, doesn't listen) ☐ No ☐ Yes (explain) _____

      _____
   h. Habits (thumb sucking, head banging, nail biting, frequent unusual behaviors, eating non-food items etc.)
      ☐ No☐ Yes (explain) _____
   i. Any other concerns ☐ No ☐ Yes (explain) _____

      _____
2. Last dental visit date _____ Name of Dentist/Dental practice_____

IV. Childhood Illnesses

1. Is this child presently taking any prescription or over the counter medications (allergy medication, multi-vitamin, etc)?
   ☐ No ☐ Yes please list: if need more room, please list on bottom of last page

Name of Medication	Dose	When taken	Who prescribes (or state if over the counter)

Revised: September 5, 2012; September 19, 2013; March 10, 2014; July 28, 2015; August 18, 2015

3. Has this child ever had or does he/she presently have: **please check all that apply**

☐ Frequent ear infections	☐ Asthma –who manages the asthma
☐ Difficulty hearing	☐ Pneumonia history
☐ Eye problems (crossed eyes, squinting)	☐ Stomach/Intestinal problems
☐ Wears glasses – age of current prescription?	☐ Urinary/Kidney problems
☐ Heart condition/murmur	☐ Bed wetting/stool soiling
☐ Frequent headaches	☐ Seizures
☐ Anemia (low iron)	☐ Frequent/ongoing skin rashes/condition
☐ Bleeding problems	☐ Frequent swollen glands
☐ ADHD/Mental health issues	☐ Cancer
☐ Broken bones Please list:	☐ Chicken Pox (varicella) illness. When?
☐ Serious accident Please list:	☐ Measles, mumps, or German measles illness When?
☐ Hospitalization(s) Please list:	☐ Operation(s) Please list:

If you checked any of the above, please give details for each:_____

_____

4. Is this child presently under a specialist's care? ☐ No ☐ Yes (if Yes, please list)

Where/Who	Specialty	How often is your child seen?

4. Any other medical problems? ☐ No ☐ Yes (if Yes, explain) _____

_____

5. Please list all allergies (drugs, bee stings, environmental, etc) and reactions (hives, swelling, anaphylaxis – need epi pen?):

Allergy	Reaction

V. Immunizations

1. Has this child ever had a reaction to an immunization? (high fever, uncontrollable crying, seizures, etc)
   ☐ No ☐ Yes (if Yes explain) _____
2. Has this child had a TB screening test? ☐ No ☐ Yes – When? _____ Result? _____
3. TUBERCULOSIS RISK ASSESSMENT SCREENING TOOL
   Please circle one answer for each question.

YES NO 1. Has this child had recent close contact with someone who has infectious tuberculosis or a positive skin (PPD) test?

YES NO 2. Has this child had an abnormal chest x-ray suggestive of TB?

YES NO 3. Is this child HIV positive? Or has he/she been exposed to adults who are HIV positive, IV drug users, homeless, incarcerated, or migrant workers?

YES NO 4. Has this child ever had an organ and/or bone marrow transplant or been on any immunosuppressive drugs?

YES NO 5. Has this child had an unusual persistent, productive cough; specifically coughing up thick material for more than three weeks or coughing up blood?

YES NO 6. Has this child spent more than 30 consecutive days outside the US? If yes, where_____?
When _____?

Revised: September 5, 2012; September 19, 2013; March 10, 2014; July 28, 2015; August 18, 2015

VI. Family History

Check all applicable illnesses/diseases for each family member:

Family Member	Asthma	Diabetes	Cancer	Heart Disease	Hypertension	Genetic Disease	Hepatitis B	Hepatitis C	Seizures	HIV	Tuberculosis	Alcohol/Drug Abuse	Anxiety	Depression	Other Mental Illness	ADD/ADHD	Age at Death	If deceased, cause of death
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Maternal Grandmother (mother's mother)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Maternal Grandfather (mother's father)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Paternal Grandmother (father's mother)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Paternal Grandfather (father's father)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Mother's brother/sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Father's brother/sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Other _____																		

VII. Environmental

1. Smokers in the home ☐ No ☐ Yes
2. Who lives in the home?

Name	Relationship	Age

Any other special concerns regarding this child? ☐No ☐ Yes - If yes, explain _____

Parent/Guardian name: Please print _____

Home Telephone # (_____) _____ Cell # (_____) _____ Work # (_____) _____

What is the preferred contact number during the school day? **Please circle one:**

home cell work other (_____) _____

Revised: September 5, 2012; September 19, 2013; March 10, 2014; July 28, 2015; August 18, 2015

3. PATIENT RISK ASSESSMENT FOR LEAD TESTING - Complete if child is 6 years old or younger
Please circle one answer for each question.

YES NO 1. Does this child live in and/or regularly visit a house or child care facility built before 1950?

YES NO 2. Does this child live in a house built before 1978 that is undergoing renovations or has chipping/peeling paint?

YES NO 3 Does this child have a brother or sister, housemate, or playmate being followed or ever treated for lead poisoning?

YES NO 4. Does this child frequently come in contact with an adult who has a job or hobby that involves exposure to lead? (e.g. house painting, construction, welding, battery recycling, lead smelting, jewelry or pottery making)

YES NO 5 Does your family use traditional medicine, health remedies, cosmetics, powders, spices, or foods from other countries? (e.g. alkohl, azarcon, bala goli, ghasard, greta, pay-loo-ah, DawTway, DawKyin, dhavana, or shakti)

YES NO 6. Does this child eat non-food items (pica)? Does your child put things in their mouth such as toys, jewelry, or keys?

YES NO 7. Does your family cook, store, or serve food in lead, crystal, pewter, or pottery from Asia or Latin America?

YES NO 8. Has this child lived in or spent time $\geq$ 2 months in an area outside of the USA?

If you have any questions regarding this child's health or if you would like an appointment for a physical examination for this child done at the school, please call the Student Medical Services office.

DeRuyter Central School	(315) 852-3400 x8
Appleby Elementary School	(607) 849-3180
Marathon Jr./Sr. High School	(607) 849-3900
Cincinnatus Central School	(607) 863-3200 x2 x2

THANK YOU FOR YOUR COOPERATION!

THE SCHOOL HEALTH PROGRAM STAFF

Additional information from previous pages:

Revised: September 5, 2012; September 19, 2013; March 10, 2014; July 28, 2015; August 18, 2015

Family Health Network of Central New York, Inc.

SCHOOL HEALTH PROGRAM

Consent to Obtain Medication History

Patient Name: _____ Date of Birth: _____

Patient SSN: _____

Family Health Network (FHN) has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other providers have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurance.

An accurate medication history is very important in helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form, you give us permission to collect and give to your pharmacy and your health insurance permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information may become part of your medical record based on your provider's discretion.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make the drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Family Health Network of Central New York, Inc. to obtain my medication history from my pharmacy, my health insurances, and my other healthcare providers.

Printed Name of Patient/Parent/Guardian _____

Patient/Parent/ Guardian Signature: _____
(Circle one)

Date: _____