IHPCH New Student Intake /Checklist

Student Name: _____

Mother/Gaurdian: _____

Cell # _____ Work # _____ Email: _____

*Best way to contact you: _____

Father/Gaurdian: _____

Cell # _____ Work # _____ Email: _____

*Best way to contact you: _____

Main Office:

- Lunch Forms
- Blue Card
- Immunization/Medical
- Proof of Address
- Uniform Order Form
- Cell Phone Policy

Administration:

- Introduction
- Home Language Survey

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

What to Bring With You to Registration

- The child that you are registering
- Child's birth certificate, passport, or record of baptism which includes the date of birth, or other official document of age (See Chancellor's Regulation A-101 for documents accepted for proof of age)
- Immunization records
- Latest report card/transcript (if available)
- Individualized Education Program (IEP) and/or 504 Accommodation Plan (if applicable and available)
- Proof of address which may be verified by any **two** of the following containing the address of residence:
  - *A lease agreement, deed or mortgage statement for the residence*
  - *A residential utility bill (gas or electric) in the resident's name issued by a utility company (e.g., National Grid or Con Edison), must be dated within the past 60 days*
  - *A bill for cable television services provided to the residence; must include the name of the parent and the address of the residence and be dated within the past 60 days*
  - *Documentation or letter on letterhead from a federal, state, or local government agency, including the IRS, the City Housing Authority, Human Resources Administration, the Administration for Children's Services (ACS), or an ACS subcontractor or the federal Office of Refugee Settlement, indicating the resident's name and address, must be dated within the past 60 days*
  - *A current property tax bill for the residence*
  - *A water bill for the residence dated within the past 90 days*
  - *Rent receipt which includes the address of the residence, must be dated within the past 60 days*

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

- *State, city, or other government issued identification (including an IDNYC card), which has not expired and includes the address of residence*
- *Income tax form for the last calendar year*
- *Official NYS Driver's License or learner's permit which has not expired*
- *Official payroll documentation from an employer issued within the past 60 days such as a pay stub with home address, a form submitted for tax withholding purposes or payroll receipt (a letter on the employer's letterhead is not adequate); must include home address and be dated within the past 60 days*
- *Voter registration documents, which include the name of the parent and the address of residence*
- *Unexpired membership documents based upon residency (e.g., neighborhood residents' association), which include the name of the parent and the address of residence*
- *Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers documents issued within the past 60 days with name of child and address of residence*

* If you are not the leaseholder of your residence, you must submit a Residency Affidavit.

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

August 2017

Dear Parents, Guardians, or Custodians of Newly Admitted High School Students:
Health education that teaches responsible decision-making enables students to be more productive in school and in life. As a complement to the health education that students receive, the NYC Department of Education's HIV/AIDS education program requires a Condom Availability Program (CAP) at public high schools that can help reinforce students' decision-making in and out of the health education classroom.

According to state law, through CAP, students in grades 9-12 may request free condoms, medically accurate health information, and health referrals from trained school staff.

As a parent, guardian, or custodian, you may ask the school **not** to provide your adolescent with condoms. Per Public Health Law § 2504, you are not permitted to make this request if your child 1) is 18 years of age or older; 2) has been or is currently married; 3) is a parent, and/or 4) is entitled under law to give consent for himself/herself.

To request that your child **not** receive condoms through CAP, you must write a letter to me that includes:

- Full name of student
- Grade of student
- Student's identification number (*Note: If you do not have this information, we will provide it for you)*
- The following statement: " _____ (Full name of student) should not receive condoms through the Condom Availability Program."
- Your signature as parent, guardian, or custodian

If you change your mind and decide that your child can request free condoms, you can send me a letter at any time during the school year. CAP-trained staff members are committed to ensuring the confidentiality of all students, including those who do not participate in the program.

We encourage you to have conversations about sexual health and other health topics at home to best support your young adult in making positive health choices. Thank you for working together with us to help New York City students feel valued, healthy, and able to thrive.

Sincerely,

Principal

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

Dear Parent:

Federal law requires the New York City Department of Education (DOE) to provide names, addresses, and telephone numbers of 11th and 12th grade high school students to military recruiters and institutions of higher education that request this information, except where the parent or student opts out by notifying the DOE **in writing** that he/she does not consent to release this information. While we are committed to protecting the confidentiality of our students, we must comply with the law.
If you do not consent to the disclosure of this information, you must fill out the following form and return it to your child's school by October 13, 2017. If you do not return the form by this date and your child is a student in the 11th or 12th grade, we will release your child's information upon request. However, please be aware that if you choose not to return the form at this time, you may do so at **any time** during your child's school career and the request for non-disclosure will be honored. For parents of 9th and 10th grade students, the opt-out form can be completed and saved in advance.
For more information or assistance, please refer to Chancellor's Regulation A-825 or contact the Military Recruitment Liaison in your school.

Thank you for your cooperation.

Sincerely,

Principal

PARENTAL OPT-OUT FORM
Please complete the following if you do not consent to the release of your child's information - name, address, and telephone number - to military recruiters and/or institutions of higher education that request this information.
Student's Last Name: _____
Student's First Name: _____
Student's Official Class: _____ Name of School: _____
I am requesting that my child's name, address, and telephone number **NOT** be shared with: (please check appropriate box)
_____ Military Recruiters
_____ Institutions of Higher Education
_____ Both Military Recruiters and Institutions of Higher Education
Parent/Guardian: _____ _____
Print Name Signature
_____
Date

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

Dear Student:

Federal law requires the New York City Department of Education (DOE) to provide names, addresses, and telephone numbers of 11th and 12th grade high school students to military recruiters and institutions of higher education that request this information, except where the parent or student opts out by notifying the DOE **in writing** that he/she does not consent to release this information. While we are committed to protecting the confidentiality of our students, we must comply with the law.
If you do not consent to the disclosure of this information, you must fill out the attached form and return it to your school by October 13, 2017. If you do not return the form by this date and you are a student in the 11th or 12th grade, we will release your information upon request. However, please be aware that if you choose not to return the form at this time, you may do so at **any time** during your school career and the request for non-disclosure will be honored. If you are a student in the 9th or 10th grade, the opt-out form can be completed and saved by the school.
For more information or assistance, please refer to Chancellor's Regulation A-825 or contact the Military Recruitment Liaison in your school.

Thank you for your cooperation.

Sincerely,

Principal

STUDENT OPT-OUT FORM
Please complete the following if you do not consent to the release of your information - name, address, and telephone number - to military recruiters and/or institutions of higher education that request this information.
Student's Last Name: _____
Student's First Name: _____
Student's Official Class: _____ Name of School: _____
I am requesting that my name, address, and telephone number **NOT** be shared with: (please check appropriate box)
_____ Military Recruiters
_____ Institutions of Higher Education
_____ Both Military Recruiters and Institutions of Higher Education
Student: _____ _____
Print Name Signature
_____
Date

2017-18 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 9, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 4, 5, 10, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 10 through 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2 and 3	Grades 4 and 5	Grades 6, 7, 8 and 9	Grades 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]		**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**		**2 doses**		
Hepatitis B vaccine[6]	**3 doses**		**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**		**Grades 7 and 8: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**		**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**		**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required. If the first dose was received on or after the first birthday, then 3 doses are required. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 4, 5, 10, 11 and 12 in the 2017-18 school year
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 10 through 12. Two doses are required for grades kindergarten through 9.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose. It can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7 and 8.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723 - 7301

Vision & Hearing Screening

OSH is improving its vision programs to ensure that all children are screened, and that children with serious vision problems receive the evaluation and treatment they need. National data indicate that about 25% of students need glasses by the time they reach high school. Furthermore, about 3% of children suffer from amblyopia, a condition that may result in blindness in one eye if not detected and treated before age seven.

Vision Screening

New York City Department of Education school staff are responsible for vision screenings of all students not screened by DOHMH as well as for entering the results on the appropriate Automate the Schools (ATS) screen. Chancellor's Regulations require that vision screenings be performed for the following students:

Priorities

- Pre-kindergarten, Kindergarten, and grades 1, 3, and 5
- New Entrants
- Students referred for Special Education evaluation as well as students currently enrolled in Special Education classes
- Teacher referrals for students who may be having difficulties
- Students whose previous test indicated other than normal or high risk.

Vision Resource List

FACILITY	ADDRESS	PHONE#	HOURS	LANGUAGE
BROOKLYN				
CONEY ISLAND HOSPITAL	2601 Ocean Parkway (Ave Z)	718-616-3703	M-F 8-4	ALL
DOWNSTATE UNIV HOSPITAL EYE CLINIC	2171 Nostrand Avenue	718-270-1714	M-F 8-5	ALL
EAST NY DIAG & TREATMENT CENTER	2094 Pitkin Avenue	718-240-0440	M-F 9-4	ALL
BISHOP O. WALKER CLINIC INTERFAITH PEDIATRIC	528 Prospect Place	718-613-6882	TH 11-3	ALL
KINGS COUNTY HOSPITAL CENTER	451 Clarkson Avenue East Building 8th Floor, Suite A	718-245-3055	M-F 8-4	ALL
LUTHERAN MEDICAL CENTER	150 55th Street, Station 14	718-630-7942,7269	M, Th, F 8-3:30, T, W 1-6	ALL
WOODHULL HOSPITAL	760 Broadway, Suite 2B	718-963-8603	M, T, TH 8-3 W 11-5	ALL
BRONX				
JACOBI MEDICAL CENTER	1400 Pelham Pkwy South, Building 8-2D	718-918-6566,5700	M-F 9-5	ALL
LINCOLN MEDICAL CENTER	234 East 149th Street, Room 2A6	718-579-5693,5610	M-F 8:30-5	ALL
MONTEFIORE MEDICAL CENTER	3400 Bainbridge Avenue 4141 Carpenter Avenue, 3rd Floor 2300 Westchester Avenue 1180 Morris Park	718-920-2020	M-F 8-5 APPTS ONLY	ALL
MORRIS HEIGHTS HEALTH CENTER	57 West Burnside Avenue, Rm B2	718-716-4400 x2261,2262	M,T,TH 9-4 W 10-6 S 9-1	ALL
MORRISANIA DIAGNOSTIC & TREATMENT CENTER	1225 Gerard Avenue, Room 3D	718-960-2813	M-TH 8:00-4:30 APPTS ONLY	ALL
NORTH CENTRAL BRONX HOSPITAL	3424 Kossuth Avenue, Room 10A	718-519-3630	M-F 9-1, T-F 9-2 APPTS ONLY	ALL
ST BARNABAS HOSPITAL	4487 Third Avenue	718-960-6389	M, W,TH 9-11, T 1-3	ALL
UNION COMMUNITY HEALTH CENTER	260 East 188th Street, 2021 Grand Concourse, 470 East Fordham Road	718-220-2020	M,T,TH, F 9-3, W 9-6	ALL
MANHATTAN				
BELLEVUE HOSPITAL ENT CLINIC	462 1st Avenue, Suite 3A	212-562-1782	M, T, W 12:30-2	ALL
EDWARD S. HARKNESS EYE INSTITUTE	635 West 165th St (Ft Washington)	212-305-6185	M-F 8-5 APPTS ONLY	ALL
GOUVERNEUR HC SERVICES (EYE CARE)	227 Madison Street	212-238-7897	M,T,TH 8-4 W & F 8-5	ALL
HARLEM HOSPITAL CENTER EYE CLINIC	46 West 137th Street	212-939-8210	M-F 8-4 APPTS ONLY, WALK-IN EMERGENCY ONLY	ALL
KRESS/ NYU DOWNTOWN HOSPITAL	156 William Street	212-233-8483	T, W, TH AFTER 1 APPTS ONLY	ALL
LENOX HILL HOSPITAL	210 East 64th Street (2nd-3rd Ave)	212-702-7340	MON ONLY 8:30-12:30	ALL
METROPOLITAN HOSPITAL	1901 1st Avenue (97th St)	212-423-6503	M, T, TH 9-12, W, F 9-4	ALL
MOUNT SINAI HOSPITAL (NYU HEALTH)	17 East 102nd Street, 8th Floor	212-241-7676	M-F 8-5	ALL
NEW YORK EYE & EAR INFIRMARY	310 East 14th Street (off 2nd Ave)	212-979-4192	MON-FRI 7:30-3 APPTS & MON-FRI 7:30-12 WALK IN	ALL, Sign Lang
SUNY UNIVERSITY EYE CENTER	33 West 42nd Street (5th-6th Ave)	212-938-4001	M, W,TH 9-6, T 1-6, F & S 9-1	ALL
QUEENS				
ELMHURST HOSPITAL EYE CLINIC	79-01 Broadway, Room H238	718-334-3235	M-F 9-5, APPT ONLY	ALL
JAMAICA HOSPITAL - TJH OPHTALMOLOGY CENTER	134-20 Jamaica Avenue	718-206-5900	M-F 8:30-5	ALL
JAMAICA HOSPITAL - MEDISYS ST. ALBANS	111-20 Merrick Blvd (111th-Sayers Avenue)	718-206-9888	M,W,TH 8-6, T 8-7, F 8-5, S 8-4	ALL
NEW YORK PRESBYTERIAN QUEENS EYE CENTER	174-15 Horace Harding Expwy	718-661-8800	M-F 8-4 APPTS ONLY	ALL
QUEENS HOSPITAL	82-68 164th Street Pavilion Building, Room 452	718-883-3060	M-F 8-4 APPTS ONLY	ALL
STATEN ISLAND				
RICHMOND UNIVERSITY MEDICAL CENTER	355 Bart Avenue	718-818-4848	T, W, F 9-2	ALL
STATEN ISLAND UNIVERSITY HOSPITAL	242 Mason Avenue, 2nd Floor, Suite 5	718-226-6919	MON ONLY 8:30-11	ALL

Rev. June 2016

DOHMH/Office of School Health

You may contact your own eye doctor or call one of the above facilities for an appointment.

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOL-BASED HEALTH PROGRAM

☑ Campus Magnet High School
207-01 116th Avenue
Cambria Heights NY 11411
Tel: (718) 949-6010
Fax☹718) 949-6210

☐ P. S. 155
130-02 115th Avenue
S. Ozone Pk., NY 11420
Tel: (718) 322-4850
Fax#(718)641-8931

☐ P. S. 223
125-20 Sutphin Blvd
Jamaica, NY 11436
Tel: (718)322-9086
Fax#(718) 529-0852

INFORMATION NEEDED

Name of child _____

Date of Birth (DOB) _____

Child's Social Security _____

Name of person providing Insurance _____

Name of Insurance _____

Insurance ID # _____

Group # _____

Health Plan _____

_____ No, I would not like Jamaica Hospital Medical Center to contact me for assistance obtaining insurance.

JAMAICA HOSPITAL MEDICAL CENTER

SCHOOL-BASED HEALTH PROGRAM

☑Campus Magnet High School
207-01 116th Avenue
Cambria Heights NY 11411
Tel: (718) 949-6010
Fax⊗718) 949-6210

☐P. S. 155
130-02 115th Avenue
S. Ozone Pk., NY 11420
Tel: (718) 322-4850
Fax#(718)641-8931

☐P. S. 223
125-20 Sutphin Blvd
Jamaica, NY 11436
Tel: (718)322-9086
Fax#(718) 529-0852

Dear Parent / Guardian:

I am writing to request updated health insurance information for your child's medical chart at the Jamaica Hospital School-Based Health Clinic (SBHC). The SBHC is a grant funded program that receives its funding from the NYS Department of Health. Unfortunately, the program does no receive all of its funding from the grant. In addition to grant money, the NYS Department of Health allows the SBHC to receive funding by billing insurance companies for services provided at the clinic. However, there is no direct charge to you for these services.

We ask you for your insurance information in an attempt to bill your insurance company for the services provided. If your insurance company does not pay for the services, you will not be billed. If at any time, due to computer error, you do receive a bill, please fax us a copy or bring the bill to the School-Based Health Center and we will send it for correction in our system.

We would appreciate you providing us with your child's current insurance information. Please complete the form on the back of this letter and return it to the medical office. Again, there will be no co payment or deductible billed to you at any time. If you do not have insurance for any members of your family, our representative with financial aid at JHMC will contact you to assist in obtaining an insurance plan. If you do not want this assistance, please check "No" on the back of form.

Thanks you in advance for your assistance and cooperation. Please do not hesitate to contact us, at the numbers above, if you have any questions or concerns.

Jamaica Hospital Medical Center
School-Based Health Team

NYC Department of Education
Carmen Fariña, Chancellor

FORM
PSE

THE NEW YORK CITY DEPARTMENT OF EDUCATION
PARENT/GUARDIAN STUDENT ETHNIC IDENTIFICATION

- All students between 5 and 21 years of age have the right to a free public education.
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability,sexual orientation, religion, or ethnicity.1

English Only

HEADER INFORMATION

Borough ☐ District ☐☐ School ☐☐☐ Name of High School/ Mini School/Annex _____

Grade Code ☐☐☐ Class Code ☐☐☐☐ (HIGH SCHOOL ONLY 4-DIGIT) NYC Student Identification Number ☐☐☐☐☐☐☐☐☐

Date of Birth (Month/Day/Year ☐☐☐☐☐☐

Student Name: Last, First, Middle Initial

DIRECTIONS TO PARENT/GUARDIAN

PLEASE REVIEW THE RACIAL/ETHNIC DEFINITIONS BELOW BEFORE YOU RESPOND.
Check (√) the one that best describes your child.
Check (√) only ONE category.

☐ **AMERICAN INDIAN OR ALASKAN NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit. (ATS - Code 1)

☐ **ASIAN OR PACIFIC ISLANDER:** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Pacific Islands, or the Indian subcontinent. This area includes, e.g. China, India, Pakistan, Bangladesh, Sri Lanka, Japan, Korea, the Philipine Islands, and Samoa. (ATS - Code 2)

☐ **HISPANIC:** A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin - regardless of race. (ATS - Code 3)

☐ **BLACK, NOT OF HISPANIC ORIGIN:** A person having origins in any of the Black racial groups of Africa. (ATS Code 4)

☐ **WHITE, NOT OF HISPANIC ORIGIN:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. (ATS Code 5)

☐ **MULTIRACIAL:** A person having origins in two or more of the above mentioned groups. (ATS Code 7)

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student:

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify) _____

PUPIL ACCOUNTING SECRETARY: Please enter numeral (1-7) for encoding in Admission Book or on the school's automated system (UAPC, ATS) ☐

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.

NYC Department of Education School Health Program
School Parental Consent Form (Grades 9-12)
CAMPUSMAGNETHIGH SCHOOL (CMHS)

97-01 116TH Avenue, RM B19, Cambria Heights NY 11411 Tele: (718) 949-6010 Fax # (718) 949-6210

LAW & GOVERNMENT ☐ MATH & TECHOLOGY ☐HUMANITIES ☐HEALTH PROFESSIONS

BUSINESS &COMPUTERS ☐FINANCE AND INFORMATION TECHNOLOGY

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: ____/____/____ (Month / Day / Year)

Sex: ☐ Male ☐ Female Grade _____

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐Asian/Pacific Islander☐Other _____

Race: _____

Religion: _____

Country of Origin: _____

Preferred Language: _____

Student's Social Security Number: _____
this information will only be used for Health Insurance purposes)

Student Address: _____

_____

_____ ____ _____
City State Zip Code

Who is the student's regular doctor?

Name: _____

Telephone: _____

Responsible Party/ Guarantor Name: _____

Address: _____

Phone: _____

Employment Information

Name: _____

Address: _____

Phone: _____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____ First Name: _____
DOB: _____
Phone Number: _____

Father
Last Name: _____ First Name: _____
DOB: _____
Phone Number: _____

Legal Guardian, If Applicable
Last Name: _____ First Name: _____
Relationship of legal guardian to student
☐ Grandparent ☐ Aunt or Uncle ☐ Other: _____

Emergency Contact Information
Name: _____
Relationship to Child: _____
Home Tel: _____
Work Tel: _____
Cell: _____

Emergency Contact Information
Name: _____
Relationship to Child: _____
Home Tel: _____
Work Tel: _____
Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

☐ No ☐ Yes: Medicaid ID # _____

Does your child have Child Health Plus?

☐ No ☐ Yes: CHP # _____

Which Plan?

☐ Affinity ☐ NYP Community Health Plan
☐Healthfirst ☐Amerigroup/Healthplus
☐ HIP ☐Fidelis
☐ Other: _____

Does your child have anyother insurance?

☐ No ☐ Yes: Name: _____

Coverage Number: _____

If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a NY State approved low-income health insurance plan?

☐ No ☐ Yes What is the best time to contact you? _____

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the CMHS School-Based Health Center.

NOTE: By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior 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. My signature indicates I have received a copy of the Notice of Privacy Practices. Your decision to grant consent is voluntary and may be revoked at any time. If you revoke consent, your revocation is not retroactive.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* Date

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

PLEASE BE SURE TO SIGN BOTH SIDES OF THIS CONSENT 6/24/2015

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified. X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* Date

SCHOOL BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of CAMPUSMAGNETHIGH SCHOOL) as part of the school health program approved by the New York State Department of Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based HealthCenter services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot) among other methods], testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. 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.
8. Dental examinations including: diagnosis, treatment, and sealants where available.
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.
11. Assessment of medical need for related services (e.g., occupational therapy, physical therapy, speech) recommended on your child's Individualized Education Plan in connection with possible Medicaid claiming for these services.

PARENTAL CONSENT FOR RELEASE OF HEALTH AND STUDENT RECORD INFORMATION

/ signature on page 1 of this form authorizes release of medical information. This information may be protected from disclosure by federal vacy law and state law.

/ signature also provides consent to the release from the School-Based Health Center to the NYC Department of Education of medical ormation as outlined below, and from the DOE to the SBHC of medical and student record information as outlined below, in order to meet gulatory requirements or assist in Medicaid and other insurance claiming, if applicable, or in connection with the student's health and rticipation in school. I understand that this information will be protected in accordance with Federal and State law and Chancellor's gulations on confidentiality.

ormation Required by Law or Chancellor's Regulation:
lew Entrant Exam (Form CH-205)
mmunizations
ision and hearing screening results
uberculin test results

ormation for Insurance Claiming Purposes:
ealth insurance coverage
dividualized Education Program (IEP) information

Information Relating to Health and Student's Participation in School:
- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV Infection/STI and other confidential services protected by law).
- Enrollment in School-Based Health Center

signature on page 1 of this form also gives my consent to CMHS to contact other providers that have examined my child and to ain insurance information.

questions about this form have been answered. I understand that I do not have to allow release of my child's medical or student record rmation, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, r a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

e Period During Which Release of Information is Authorized:
n: _____ (Date that form is signed on opposite page)

_____ (Date that student is no longer enrolled in the SBHC)

horization for Release of Information to/from JHMC: I hereby authorize and direct the above medical facility, having treated me, to use to/or receive from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical all information needed to substantiate payment for such hospitalization and medical care and to permit representation thereof to examine nake copies of all records relating to such care and treatment including for the purpose of filing an external appeal.

: _____ Signature of Patient/Authorized Representative: _____

torization of Payment: I hereby assign, and set over to the above named medical facility sufficient monies and/or benefits to which I be entitled, from government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, to r the costs of the care and treatment rendered to myself or my dependant in said hospital. In the event of denial of payment, I authorize ider to request external appeal.

_____ Signature of Patient/Authorized Representative: _____

PLEASE BE SURE TO SIGN BOTH SIDES OF THIS CONSENT 6/24/2015

Form #2 Please Sign and Return

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jamaica Hospital School Health Center C.M.H.S. 207-01 116th Ave., Cambria Heights, NY 11411 (718) 949-6010

8. Name and address of person(s) or category of person to whom this information will be sent:
PCP/SPECIALIST:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
- ☑ At request of individual
- ☐ Other:

11. Date or event on which this authorization will expire:
4 Years from Today

12. If not the patient, name of person signing form:
X

13. Authority to sign on behalf of patient:
Mother/Father/Guardian

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

JAMAICA HOSPITAL MEDICAL CENTER

School-Based Health Clinics

☐Campus Magnet High School (CMHS)	☐PS 223	☐PS 155
207-01 116th Avenue	125-20 Sutphin Blvd	130-02 115th Avenue
Cambria Heights NY 11411	Jamaica NY 11436	South Ozone Park NY 11420
Tele:(718) 949-6010	Tele: (718) 322-9086	Tele: (718) 322-4850
Fax # 718-949-6210	Fax # (718) 529-0852	Fax# (718) 641-8931

Dear Parent or Guardian:

We are happy to inform you that Campus Magnet High School, P.S. 223 and P.S. 155 all have School-Based Health Centers (SBHC). The Health Center is staffed by trained medical and social work professionals employed by Jamaica Hospital Medical Center. Your child can receive services in our center at no out of pocket expense to you, regardless of insurance status. Please know that your child can use the School-Based Health Center in addition to your other doctors. Appointments are available via walk-in or by telephone. The Clinic is open during the hours of 8:00 am – 4:00 pm. If you need assistance after hours you can speak to a pediatrician at (718) 206-8888.

School-Based Health Center Services include:

- Medical care, including treatment for acute and chronic conditions (when your child or children is sick in school.
- Complete physical examination (for Working Papers, Sports, Camp)
- Screening and referral for health insurance
- Laboratory tests
- Medication and prescription
- Health education & counseling
- Individual and group counseling
- Immunizations
- Age appropriate reproductive health care
- Screening for vision, hearing, obesity and other medical conditions

Please complete and return the forms so your child/children can obtain services. If your child is **not consented** to be seen, we are unable to provide service.

Please share with your Primary Care Physician that your child is enrolled in the Jamaica Hospital School-Based Health Center and return a copy of your child's physical (CH205 form) to the clinic. Please schedule an appointment at the School-Based Health Center (SBHC) so we may meet you and your child.

We look forward to meeting you and providing health services for your child. Signing this consent **does not** change your insurance plan or your primary care physician. Feel free to visit us at the center or call us at any of the above telephone numbers for your school, if you have any questions.

Sincerely,

Jogesh Syalee
Jogesh Syalee, MD
Director, School-Based Health Center (SBHC)

Revised 8/27/12

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers: Home / Cell / Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Other (specify) _____

Explain all checked items above or on addendum

Medications (attach MAF if in-school medication needed)

☐ None ☐ Yes (list below)

_____

_____

Dietary Restrictions

☐ None ☐ Yes (list below)

_____

PHYSICAL EXAMINATION

Height _____ cm (___ %ile)

Weight _____ kg (___ %ile)

BMI _____ kg/m² (___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive (e.g., play skills) _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment (annually, age 6 mo-6 yrs)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	___/___/___	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit (age 9-12 mo)	___/___/___	_____ g/dL _____ %

	Date Done	Results
Tuberculosis (Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school)		
PPD/Mantoux placed	___/___/___	Induration _____ mm
PPD/Mantoux read	___/___/___	☐ Neg ☐ Pos
Interferon Test	___/___/___	☐ Neg ☐ Pos
Chest x-ray (if PPD or interferon positive)	___/___/___	☐ NI ☐ Abnl ☐ Not indicated
Vision (required for new school entrants and children age 4-7 yrs)	___/___/___ ☐ with glasses	Acuity Right ___/___ Left ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B ___/___/___ ___/___/___ ___/___/___ ___/___/___

DTP/DTaP/DT ___/___/___ ___/___/___ ___/___/___ ___/___/___

___/___/___ ___/___/___ ___/___/___ ___/___/___

PCV ___/___/___ ___/___/___ ___/___/___ ___/___/___

MMR ___/___/___ ___/___/___ ___/___/___

Td ___/___/___ ___/___/___ ___/___/___

Meningococcal ___/___/___ ___/___/___

Other, specify: _____ ___/___/___; _____ ___/___/___

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems (list) ICD-9 Code

_____ _____

_____ _____

_____ _____

Health Care Provider Signature | Date ___/___/___

Health Care Provider Name and Degree (print) | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

DOHMH USE ONLY

CH-205 (5/08)

Copies: White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian

Department of Education

McKinney-Vento Homeless Assistance Act
Students in Temporary Housing Guide for Parents & Youth

TOPIC	IMPORTANT INFORMATION
Children living in the following situations are considered homeless for the purposes of education rights under the McKinney-Vento Act:	• In a shelter, transitional shelter, motel, campground, abandoned in a hospital, or awaiting foster care. • In a car, park, public place, bus, train or abandoned building. • Doubled up with friends or relatives because you cannot find or afford housing.
Unaccompanied Youth	• Youth who is not in the physical custody of a parent or guardian and who meets the definition of homelessness set forth in the explanation above. *Unaccompanied homeless youth have the same rights as homeless students who reside with a parent or guardian.*
Students who fall under the McKinney-Vento Act's definition of homeless have the following rights:	• To a free public education. • To immediate enrollment in the zoned school. • To attend school no matter how long they have lived at their current location. • To stay in their school of origin (school attended before becoming homeless or the last school attended) or choose to attend their new zoned school. • To transportation services to and from school. • To not be denied immediate school enrollment just because of their situation or because they lack enrollment documentation. • To not be separated from the regular school program because they are homeless. • To receive free school meals.
Important information:	• Each borough Integrated Service Center (ISC) has at least one Students in Temporary Housing (STH) Content Expert who serves as the STH liaison and manages programs and services designed to help children who are homeless pursue their education. The STH Content Expert supervises a team of Family Assistants. • Each Children First Network (CFN) has a designated STH liaison available to assist children who are homeless with their educational needs. • Additionally, District 75 and District 79 each have a designated STH liaison available to assist children who are homeless with their educational needs. • Family Assistants are located at shelters and in some schools. They are responsible for assisting homeless parents and their children with their educational needs. • Family Assistants are available to assist the child's parent/guardian with school enrollment, obtaining immunizations, school records, and arranging transportation to and from school. School staff should not hesitate to contact their STH liaison for individual questions, to arrange training, or to assist unaccompanied youth.
School Selection:	Schools must allow parents/guardians to choose the child's school when their child is homeless. The parent/guardian may choose among the following: a) The school the child attended when permanently housed (school of origin); b) The school in which the student was last enrolled; or c) Any school available to a permanently housed child residing in the area where the homeless student is currently residing.
School Enrollment: (Apply only if your child is not currently enrolled or you want to change school)	• Elementary School – register your child at your zoned school. If you are currently residing in a NYC Department of Homeless Services shelter, the family assistant at your shelter will be able to assist you, if needed. If there is no family assistant in your shelter or if you are not residing in a shelter, please contact your STH liaison for assistance. • Middle School – same procedure as elementary school except where your district does not have zoned middle schools, then you must report to the Borough Enrollment Center. For the location of your Borough Enrollment Center, please call 311. • High School – all high school students must register at the Borough Enrollment Center. For the location of the nearest Borough Enrollment Center, please call 311.
Enrollment Disputes:	• If a dispute arises over the school selection or enrollment, your child must be immediately admitted to the school in which he/she is seeking enrollment, pending resolution of the dispute. • The parent/guardian must be provided with a written explanation of the school decision on the dispute, including the right to appeal, and referred to the STH Family Assistant or STH liaison for assistance.
Transportation:	• Students who are defined as homeless by the McKinney-Vento Act are entitled to transportation to and from school, if necessary. • If available, busses will be provided to students grades K-6; if not available, they are eligible for student MetroCard. • For students in grades Pre-K to 6 who are eligible for transportation and receive a student MetroCard, their parents/guardians are eligible for public transportation assistance (MetroCard) to accompany the child. • Students in grades 7-12 are eligible for student MetroCard.

For more information, please contact your borough Integrated Service Center or your Children First Network to speak to an STH liaison or call 311.

Department of Education

Residency Questionnaire

Parent/Guardian/Student:

This form is intended to address the McKinney-Vento Act 42 U.S.C. 11435, and must be completed for each student. The information you provide is confidential. Your child will not be discriminated against based upon the information provided.

Please complete the following questions regarding the student's housing in order to help determine services the student may be eligible to receive.

Note to schools/Temporary Housing Liaisons: **Please assist students and families in filling out** this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

Student Name			
Last	First		Middle
OSIS #	Date of Birth MM/DD/YY	Gender	School

Please identify the student's current living arrangements. Please check one box:

Check (√)	Residency Questionnaire Choice	School Use Only ATS Code
	Doubled-Up With another family or other person because of loss of housing or as a result of economic hardship	D
	Shelter Emergency or transitional shelter	S
	Awaiting Foster Care Placement	A
	Hotel / Motel Living in what is NOT an emergency or transitional shelter **and** involves payment	H
	Other Temporary Living Situation Trailer park, campground, car, park, public places, abandoned building, street, or any other inadequate living space	T
	Permanent Housing Student who is living in a fixed, regular, and adequate housing situation	P

If the student is NOT living in permanent housing, also indicate if the below applies:

		School Use Only Enter "Y" if applicable
	Unaccompanied Youth Youth who is not in the physical custody of a parent or guardian	

Parent/Guardian Name (print) _____ Parent/Guardian Signature _____ Date _____

Please return this form to your child's school as requested.

Note: The answer you give above will help determine what services you or your child may be eligible to receive under the McKinney-Vento Act. Students who are protected under the Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. After the student has been enrolled, the new school must contact the last school attended to request the student's educational records, including immunization records, and Students in Temporary Housing (STH) Liaison(s) must help the student get any other necessary documents or immunizations. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

This form is accompanied by a one-page attachment titled,
"McKinney-Vento Homeless Assistance Act – Students in Temporary Housing Guide for Parents & Youth."

NYC Department of Education
Carmen Fariña, Chancellor

FORM
PSE

THE NEW YORK CITY DEPARTMENT OF EDUCATION
PARENT/GUARDIAN STUDENT ETHNIC IDENTIFICATION

To the Parent/Guardian:

The No Child Left Behind Act requires the Department of Education to collect and record the ethnic identity of public school students. This information is used for statistical analysis, data reporting, and accountability determinations.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the reverse side of this page. Put a check (√) in the box for the category which best describes your child.

The New York City public school system understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential.

Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff:

This form will be filed in the student's Cumulative Record folder as confidential information

To the Parent/Guardian

The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

1 Race may be considered as a factor in school enrollment only where required by court order; gender is a factor only in single-gender schools.

Please complete the form on the reverse side of this page.

Department of Education

Office of Communications and Media Relations
52 Chambers Street, New York, NY 10007
Tel: 212.374.5141 Fax: 212.374.5584

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE

(e.g. educational, public service, or health awareness purposes)

Student Name: _____ School: _____

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or video tapes of the Student named above by_____.

I also grant to _____the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature of Parent/Guardian (if Student is under 18): _____ Date: _____

Address of Parent/Guardian: _____

OR

Signature of Student (if 18 or over): _____ Date: _____

Address of Student: _____

IMPORTANT NOTICE TO PARENTS / GUARDIANS!

- New York State Commissioner of Education Regulations requires every student to have a physical examination before participating in senior high school interscholastic sport activities.
- The physical examination and the Department of Health/Department of Education Sport Examination form may be completed by the Department of Health physician at no cost to you, or, by your personal physician.
- The attached Sports Examination form is more comprehensive than the form it replaced. The purpose of this new form is to ensure that your child receives a complete physical examination prior to participating in interscholastic sports.
- The American Academy of Pediatrics, the New York City Department of Health and the Department of Education strongly recommend that every student have a complete physical examination including the Maturation Index prior to competing in interscholastic athletics. The Maturation Index* notes the stage of pubertal development and should be included for the protection of the student. The index is one indicator of a child's bone development and is helpful to the physician in assessing the total development of the child and his or her fitness for sports participation. However, as inclusion of the Maturation Index is optional, the parent/guardian decides whether or not the physician includes the rating. (If you do not want the physician to make an entry for the Maturation Index, write "No Maturation Index" to the left of your signature.)
- The term "clinician", appears on the Sports Examination form and refers to physicians, nurse-practitioners and physicians' assistant. The physical examination may be performed by any of these medical personnel.
- As the Sports Examination form indicates, the student's medical record is strictly confidential and is on file in the school medical office. The student's medical record is not part of his or her academic record, and is not subject to examination by anyone except authorized personnel.

<u>PLEASE NOTE:</u> ALL STUDENTS SHOULD RECEIVE REGULARLY SCHEDULED COMPLETE PHYSICAL EXAMINATION BY A PHYSICIAN OF THE PARENT/GUARDIAN'S CHOICE.

Parent notice misc. 02 25-1190.00.5 (250 PKGS) 2/03

***For more detailed information about the Maturation Index, please consult your physician**

Institute for Health Professions at Cambria Heights

Institute for Health Professions at Cambria Heights
207-01 116th Ave
Cambria Heights, NY 11411
(718) 723-7301
information@ihpch.org
www.ihpch.org

School Supply List

- ☐ 1 Backpack/Messenger Bag
- ☐ #2 Pencils
- ☐ 1 Pencil Pouch
- ☐ 1 Pencil Sharpener
- ☐ Pens (Blue or Black ink only)
- ☐ Regular Markers
- ☐ 3 Highlighters
- ☐ 1 12" Ruler
- ☐ 1 Dictionary
- ☐ 1 Thesaurus
- ☐ 6 Pocket Folders
- ☐ 2 1" or 1½" 3-Ring Binders
- ☐ Tabbed Dividers for 3-Ring Binders
- ☐ Loose-Leaf Filler Paper (College or Wide Ruled)
- ☐ 1 Pack of Graph Paper
- ☐ 1 Pack 3X3 Sticky Notes
- ☐ 1 Mini Stapler
- ☐ 1 Pack of 3x5 Index Cards
- ☐ 3-Ring Binder Hole Punch
- ☐ 1 USB Flash Drive
- ☐ 1 Combination Lock
- ☐ 1 Hand Sanitizer
- ☐ TI-84 Graphing Calculator **(Optional, but highly recommended)**