ROOSEVELT SCHOOL-BASED HEALTH PROGRAM
1 Wagner Ave
Roosevelt, NY 11575
(516) 345-7229

A Joint Program of the Roosevelt Union Free School District
And the Nassau Health Care Corporation

PARENT CONSENT FORM

SS#: _____

Name of Student: _____ Date of Birth: _____

Name of Parent/Guardian: _____

Address: _____

Telephone Home: _____ Parent/Guardian's Work: _____

Emergency Contact Person: _____ Telephone: _____

Medicaid I D Number (use # above the name): _____

Is student covered by any other Insurance? **Yes** ☐ **No** ☐

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Policy# _____ Group: _____

I hereby designate the SBHC/NUMC as my Primary Care Provider ☐

I authorize payment of medical benefits to the above provider for services rendered. (Make checks payable to "Nassau Health Care Corporation")

I authorize the release of medical or other information about this claim. A photocopy of this authorization shall be as valid as the original.

PARENT CONSENT FOR HEALTH SERVICES

I hereby give my consent for my son/daughter (indicated above) to receive "no cost" health care provided by the physician, nurse practitioner and other State-licensed health professionals of the Roosevelt School-Based Health Program and low cost care at Freeport-Roosevelt Health Center, to include the following comprehensive health care services as part of a school heath program sponsored by New York State Department of Health.

Complete physical checkup and lab tests, including sports physical
Hearing, Vision, scoliosis and blood pressure screening
Immunizations
First Aid
Prescriptions and treatment for illness
Prenatal care and verification of pregnancy
Dental screening prophylaxis, and Dental treatment
Testing and treatment of sexually transmitted diseases
Health education, nutrition and weight problems
Counseling for school and personal problems
Provision of health services at the Freeport-Roosevelt Health Center after school hours and during school Vacations.

I grant permission for my child to enroll in the Roosevelt School-Based Health Program.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. I understand that confidentiality between the student and the medical team will be ensured in specific service areas and will not be discussed with the parent or guardian unless the student agrees. The staff of Roosevelt School-Based Health Program considers parental involvement important. The staff will encourage students to involve her/his parent or guardian n counseling and medical care.

Parent/Guardian: _____ Date: _____

Parent or Guardian Information

Name: _____ D.O.B: _____ Relation: _____

Address: _____ City:_____ State: _____ Sex: _____

Zip Code: _____ Country: _____ County: _____ Marital Stat: _____

H-Tel: _____ B-Tel: _____ SS#: _____

Emply: _____ Insured: _____ N.O.K: _____

Employment Information

Company Name: _____

Address: _____ Contact: _____

Zip Code: _____ City: _____ State: _____

Country: _____ Emp. Type:_____ Years Emp: _____

Tel #: _____ Occupation: _____ Title: _____