Ryan Health
Caring for New York. Here for You.

It's fast and easy for your child to receive health care services through the Ryan Health School-based Health Center!

Dear Parent or Guardian:

We are happy to inform you that the Booker T. Washington Middle School: MS54 has a School Based Health Center (SBHC)! The SBHC is run by Ryan Health. The SBHC is staffed by Ryan Health licensed professionals consisting of medical and mental health providers.

Please know that your child can use the School-Based Health Center and see your other doctors as well. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their primary doctor.

At the School Based Health Center, your child can receive the services listed below at **no cost** to you, regardless of insurance status. The SBHC is allowed to bill insurance, however there are **no co-pays for you**, and **you do not receive a bill.**

School Based Health Center Services include:

- Complete physical examinations
- Medications and prescriptions
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions
- Age appropriate reproductive health care
- Health Education and Counseling
- Mental Health Counseling and services
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Access to care 24 hours/day, 7 days/week

To register your child for the services of our School Based Health Center, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

- ☺ **Parental Consent Form**
- ☺ **Health History Form**
- ☺ **Influenza (Flu) Vaccine Consent Form (Optional)**

Give the completed forms to your school office or teacher, or directly to the School Based Health Center in room 134. The School Based Health Center is open every school day between the hours of 8:00am-4:00pm. We look forward to meeting you and we look forward to providing health services to your child. Feel free to visit us at the School Based Health Center in room 134 or call us at 212-666-2261 for more information.

Sincerely,

Lydia Yeager, DNP, MSN, RN, CPNP-PC
Director of School Based Health
Ryan Health

Valentine Hernandez, MA
Executive Director
Ryan Health - Women and Children's

Elana Elster, Ed.D, Principal
Booker T. Washington Middle School: MS54

Ryan Health School-based Health Center Parental Consent Form

Booker T. Washinton Middle School: MS54
103 West 107th Street, Room 134, New York, NY 10025

Please know that your child can use the School-Based Health Center and see your other doctors.
Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

STUDENT INFORMATION

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Student Address:_____
_____
City State Zip Code
Student email:_____

***Student Social Security Number:** _____
Sex: ☐ Male ☐ Female Grade _____

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Other _____
List the student's regular doctor, if they have one?
Name: _____
Telephone: _____
Address: _____

Indicate the Pharmacy where we can send prescriptions.
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____
***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

Parent/ Legal Guardian:
Last Name: _____ First Name: _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

Parent/Legal Guardian:
Last Name: _____ First Name: _____
Home/ Work Tel:_____
Cell Phone:_____
Email :_____

If legal guardian , relationship to the student:
☐ Grandparent ☐ Aunt/Uncle ☐ Foster Parent ☐ Other: _____
Home /Work Tel: _____
Cell: _____
Email: _____
Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Home or 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 ☐ Fidelis
☐ Healthfirst ☐ Empire BC/BS Health Plus
☐ Emblem Health(HIP/GHI) ☐ Metro Plus
☐ WellCare ☐ United Healthcare

Does your child have other health insurance
☐ No ☐ Yes, Health Plan: _____
Member ID/Policy Number: _____
Health Insurance Phone: _____

If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?
☐ No ☐ Yes What is the best time to contact you? _____

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

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 Ryan Health School-Based Health Center. 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, married or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

X _____ _____
Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in Box 2 on reverse side of this form. My signature indicates my consent to release medical information as specified in the box 2 section only.

X _____ _____

Ryan Health School-based Health Center Parental Consent Form

SCHOOL BASED HEALTH CENTER SERVICES — BOX 1

I consent for my child to receive health care services provided by the State-licensed health professionals of the Ryan Health 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 Health Center 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. For Adolescent Students: Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot), LARC, other FDA approved methods] testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
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 and medically indicated.
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.

NEW YORK CITY DEPARTMENT OF EDUCATION'S — BOX 2
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information as specified below. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information as specified below to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

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

I authorize the Ryan Health School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the School-Based Health Center to the NYC Department of Education and from the NYC Department of Education to the School-Based Health Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information Required by Law or Chancellor's Regulation including but not limited to:

* Comprehensive Physical Exam (Form CH-205 or Equivalent such as sports exams, etc.)
* Vision and hearing screening results
* Immunizations (required/recommended)
* Tuberculin Test results

Information to Protect Health and Safety:

* Conditions which may require emergency medical treatment including chronic illness
* Conditions which limit a student's daily activity
* Diagnosis of certain communicable diseases (does NOT include HIV/STI information and other confidential services protected by law).
* Health insurance coverage
* Enrollment in School-Based Health Center
* Individualized Education Program (IEP)

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page **To**: Date that student is no longer enrolled in the SBHC

NOTE: This School Based Health Center Parental Consent Form has been approved by DOE/OSH

The William T. Harris School: PS11

☐ New Registration ☐ Registration Update

Student's Name: _____ Date of Birth: _____

National Origin (country of birth) _____Primary Language_____ Secondary Language _____

Your child's health is important to his/her ability to function well in school. To help the school based health team to be aware of your child's health in case of emergency, please complete this survey. **Please check YES or NO and explain if YES.**

CONDITIONS	YES	NO	If YES, Explain Briefly
Vision or Hearing Problems			Glasses? ☐Yes ☐No
Asthma ☐ Intermittent ☐ Persistent (mild/mod/severe) If you checked yes, you MUST turn in a completed MAF form from your primary care provider to our SBHC before your child is allowed to bring his/her inhaler to school, whether or not they store it in the SBHC or carry it with them.			Inhaler/Medication:
Allergies to Medication/Food **If your child has severe allergies that may require treatment with an EpiPen, you MUST turn in a completed Allergies/Anaphylaxis Medication Administration Form (AAMAF) from your primary care provider to our SBHC before your child is allowed to bring his/her EpiPen to school			Allergens (Reactions): EpiPen Prescribed? ☐Yes ☐No
Speech Difficulties			
Sickle Cell Disease or Trait			
Behavior Problems			
Seizures			Medication:
Mental Health Issues			
Kidney Problems			
Heart Problems or Murmurs			
Diabetes			Medication:
Family History of Illness			Indicate illness & family member:
Any other injuries or problems			
Has your child ever spent any time in the hospital?			Indicate reason, date and length of stay:
History of Chicken Pox?			What age?
Is your child taking any medicines now?			Include name, dose and how often given:

Physical Exam and immunization Information:

We **must** have proof of a current physical exam (within the past 12 months) and record of vaccinations in your child's medical record. Please choose from the following options:

☐ Yes, my child had a physical in the last 12 months.
- ☐ I have attached a copy of this exam and the Vaccine record to this form
- ☐ I will provide one to the Ryan School Based Health Center as soon as possible

☐ No, my child has not had a physical in the past 12 months.
- ☐ I will make an appointment with his/her primary care provider and I will provide the Ryan School Based Health Center with a copy of the exam and the vaccine record as soon as possible
- ☐ Please contact me to set up an appointment for my child to have a physical exam

Dental Exam Information:

☐ Yes, my child had a dental exam in the last 12 Months: **Date___/___/___**

☐ No, my child has not had a dental exam in the last 12 months.

Parent/Guardian Signature: _____ **Date:** _____

REV 6/2017

RYAN HEALTH NETWORK

WILLIAM F. RYAN ♦ RYAN/CHELSEA-CLINTON ♦ RYAN-NENA ♦ RYAN/ADAIR
RYAN WOMEN & CHILDREN'S ♦ RYAN/FREDERICK DOUGLASS
COMMUNITY HEALTH OUTREACH ♦ SCHOOL BASED HEALTH CLINICS

NOTICE OF PRIVACY PRACTICES

Effective Date: 10/17/2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our medical group, its medical staff and affiliated health care providers who jointly perform health care services with our medical group, including physicians and physician groups who provide services at our facilities. A copy of our current notice will always be posted at all registration and/or admission points. You will also be able to obtain your own copies by accessing our website at www.ryancenter.org.

If you have any questions about this notice, require further information, or need a copy of the current notice of privacy practices, please contact any of the Ryan Health Network's Privacy Officers or Site Designees:

All sites: Jonathan Fried, Privacy Officer (212-531-7568).
Ryan Women & Children's: Jenny Castro, Site Designee (212-769-7270).
Ryan-NENA: Chaitali Baviskar, Site Designee (212-477-8874).
Ryan/Adair: Rodney Grimes, Site Designee (212-222-5210).
Ryan/Frederick-Douglass and CHO Sites:
Daniel Cintron, (212-316-8340).
Ryan/Chelsea-Clinton: Bernadette Bryant, Site Designee Privacy Officer (212-484-5866).

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient in the Ryan Health Network or receiving health-related services from our facilities, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside of the Ryan Health Network. There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Psychotherapy Notes. We may not use or disclose your psychotherapy notes, if any, without your written authorization.

Marketing. We may not disclose any of your health information for marketing purposes if the Ryan Health Network, or any member thereof, will receive direct or indirect financial remuneration not reasonably related to the Ryan Health Network's cost of making the communication.

Sale of Protected Health Information. We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and/or permitted by law.

We will not use your health information for any other type of use or disclosure that is not described in this Notice without first obtaining your written authorization to do so.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to a Privacy Officer at the Ryan Health Network. You may also initiate the transfer of your records to another person by completing a written authorization form.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

1. Treatment, Payment and Health Care Operations.

Treatment. We may share your health information with doctors or nurses in the Ryan Health Network who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor in the Ryan Health Network may share your health information with another doctor to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Health Care Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

2. Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health- related benefits and services that may be of interest to you.

3. Business Associates. We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

4. Friends and Family Designated to be Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

5. **Proof of Immunization**. If a school is required by State or other law to have proof of immunization prior to admitting a student, and a child is a student or prospective student of such a school, we may disclose to the school proof of a child's immunization if a parent, guardian, other person acting in loco parentis, or the individual, if an adult or emancipated minor, authorizes us to do so, but we do not need written authorization.

6. Emergencies or Public Need.

Emergencies or As Required By Law. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. We may use or disclose your health information if we are required by law to do so, and we will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if permitted by law. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority authorized to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.

Law Enforcement. We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.

To Avert a Serious and Imminent Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military and Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors. In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the event of your death or impending death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.

7. **Completely De-identified or Partially De-identified Information.** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de- identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

8. **Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

9. **Fundraising.** We may use or disclose your demographic information, including, name, address, other contact information, age, gender, and date of birth, dates of health care provided to you, department of service information, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication made to you, you will have the opportunity to opt-out of receiving any further fundraising communications. We will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.

10. **Plan Sponsor.** The group health plan or a health insurance issuer or HMO with respect to a group health plan may disclose your health information to the sponsor of the group health plan.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. We will notify you of any changes.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights to access and control your health information:

1. Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the appropriate Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed. We may charge additional fees for the labor and supplies to provide the copy of your health information in an electronic format. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

2. Right to Amend Records. For as long your health information is kept in our records, you may request the information to be amended if you believe it is incorrect or incomplete. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. Your right to amend your health information does not include the right to have any information removed or deleted from your records.

3. Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures," which is a list of information about how we have shared your health information with others. To make your request for an accounting of disclosures, please write to the appropriate Privacy Officer. The maximum time period that your request may cover is six (6) years prior to the date of your request. You have a right to submit one request every 12- month period at no charge. However, we may charge you for the cost of providing any additional lists in that same 12-month period.

4. Right to Receive Notification of a Breach. You have the right to be notified if there is a probable compromise of your unsecured protected health information within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

5. Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. You also have the right to request that your health information not be disclosed to a health plan if you have paid for the services in full, and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the appropriate Privacy Officer. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.

6. Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home, by notifying the registration associate who is assisting you. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

7. Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

8. Right to Obtain a Copy of Notices. If you are receiving this notice electronically, you have the right to a paper copy of this notice. We may change our privacy practices from time to time. If we do, we will revise this notice and post any revised notice in our registration area and on our website

9. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us by calling the appropriate Privacy Officer, or with the Secretary of the Department of Health and Human Services. The Ryan Health Network will not withhold treatment or take action against you for filing a complaint.

10. Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Patient Plate – Ryan Health Network Use Only

RYAN HEALTH NETWORK

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Ryan Health Network as listed at the beginning of this notice, and how I may obtain access to and control of this information. By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Ryan Health Network, its staff, and its business associates.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

INFLUENZA (FLU) VACCINE CONSENT

Dear Parent or Guardian:

Ryan Health's School Based Health Program is pleased to be able to offer the seasonal influenza (flu) vaccine to any student who is registered with the School Based Health Center. We will start to administer the flu vaccine as soon as we receive the vaccine supply. Your child will bring home a note stating which vaccine (shot or intranasal) they received on the day it is given. If your child receives the flu vaccine elsewhere prior to being given at the School Based Health Center, please notify us immediately so that we do not give them an extra influenza vaccine. If you would prefer to be present during vaccination, you may call the clinic and schedule an appointment.

What parents need to know:

The flu vaccine is updated every year to combat the different strains of the flu virus that research indicates are most likely to cause illness during the coming season. The ACIP recommends that everyone over 6 months old receive the seasonal influenza vaccine to prevent serious illness. The influenza vaccine consists of a series of one or two shots, depending on your child's age and previous vaccination history against the flu. Children under age 9 should receive 2 vaccines, 4 weeks apart, if they have never received the seasonal flu vaccine before. Children age 9 and older and children who have previously received two doses of influenza vaccine will only need one dose of the seasonal flu vaccine.

We have both the intranasal (nose) and injection form of the seasonal flu vaccine. The type of vaccine that your child receives will be based on their medical history and current supply at the school based health center.

What you need to do:

If you are interested in having your child receive the flu vaccine at Ryan Health's School Based Health Center, please complete the screening and consent form on the reverse side of this letter and have your child return it to his/her teacher or to the SBHC directly. **We will not vaccinate your child unless we have signed consent and it is the responsibility of the parent/guardian to notify Ryan Health if there is any reason we should NOT go through with administering the flu vaccine after this consent form has been submitted.** If you have any questions about the vaccines or influenza, please feel free to call us anytime at **212-666-2261**. You may also visit the New York City Department of Health website at www.nyc.gov/flu, speak with your child's regular health care provider, or call the CDC at 1-800-232-4636.

Sincerely,

The Ryan Health School Based Health Program Staff

Name_____ **Date of Birth**____/____/____ **Class**_____

Part 1: This question lets us know if we should schedule your child to receive the influenza vaccine.		
1) **Would you like your child to receive the seasonal influenza vaccine from the SBHC?** STOP here if you answered "NO" to the above question.	**Yes**	**No**
Part 2: These questions will tell us if it is safe for your child to get the influenza vaccine.		
3) Has your child had a ***bad*** reaction to an influenza vaccine before? If **Yes**, please describe here:	**Yes**	**No**
4) Does your child have an allergy to eggs? If **Yes**, please describe severity of reaction here:	**Yes**	**No**
5) Has your child ever had paralysis (inability to move all or part of the body) with Guillain-Barré Syndrome (GBS)? If **Yes**, please describe here:	**Yes**	**No**
Part 3: These questions will tell us if your child should get one or two doses of influenza vaccine. *If your child is under 9 years of age and has not received 2 doses of the seasonal influenza vaccine before July 2020, they will need to receive a second dose in 4 weeks.*		
6a) Has your child ever received seasonal influenza vaccine before?	**Yes**	**No**
6b) If **Yes to 4a**: Has your child received at least 2 doses of the influenza vaccine before July 2020?	**Yes**	**No**
Part 4: These questions will give us more information prior to administering the influenza vaccine. *Please note that the SBHC must give the injection (shot) form of the influenza vaccine if you answer "yes" to any of the following questions.*		
7) Does your child have any of the following (circle): heart disease, lung disease, ***asthma***, kidney disease, diabetes or anemia?	**Yes**	**No**
8) Has your child used an albuterol inhaler or nebulizer for the treatment of cough or wheezing in the past 12 months? If so, when was the last time they used it? (date): ___/___/___	**Yes**	**No**
9) Does your child have cancer, leukemia, HIV/AIDS or other blood or immune system problems?	**Yes**	**No**
10) Has your child taken either steroids, antiviral drugs, anticancer drugs, or had cancer treatment with x-rays or radiation treatments in the past three months?	**Yes**	**No**
11) Has your child received a transfusion of blood products or been given a medication called immune (gamma) globulin in the past year?	**Yes**	**No**
12) Is your child regularly taking medications that contain aspirin?	**Yes**	**No**
13) Does your child have close contact with someone who is severely immunocompromised (such as someone in a bone marrow transplant unit of a hospital)?	**Yes**	**No**
14) Does your child have muscle or nerve disorders (such as seizure disorders or cerebral palsy) that has lead to breathing or swallowing problems?	**Yes**	**No**
15) Has your child received a live vaccine (MMR, Varicella, FluMist) in the past month? If so, when was the vaccine given? (date): ___/___/___	**Yes**	**No**

*****Please note that it is the parent or guardian's responsibility to call the school based health center at 212-666-2261 to notify us if there is any reason why we should not go through with administering the influenza vaccine after this consent form has been turned in. Please call us if:**

- **Your child received the flu vaccine from your family's pediatrician or from another clinic between turning in the consent form and the scheduled vaccine administration date**
- **Your child is feeling ill prior to and/or on the scheduled day of vaccine administration (we check every child's temperature before vaccination and we will defer vaccination if appropriate)**
- **If there is any other reason you would like to retract your consent**

By signing below, I am agreeing that I have read the Vaccine Information Statement and I want my child to receive the influenza vaccine at the School-Based Health Center.

*****Signature of Parent/Legal Guardian:** _____ **Date:** ___/___/___

Print Name of Parent/Legal Guardian:_____ **Phone Number:**_____

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**

Influenza (Flu) Vaccine (Live, Intranasal): *What You Need to Know*

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1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Live, attenuated influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

Live, attenuated influenza vaccine (called LAIV) is a nasal spray vaccine that may be given to non-pregnant people **2 through 49 years of age**.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Is **younger than 2 years or older than 49 years** of age.
- Is **pregnant**.
- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Is a **child or adolescent 2 through 17 years of age who is receiving aspirin or aspirin-containing products**.
- Has a **weakened immune system**.
- Is a **child 2 through 4 years old who has asthma or a history of wheezing** in the past 12 months.
- Has **taken influenza antiviral medication** in the previous 48 hours.
- **Cares for severely immunocompromised persons** who require a protected environment.
- Is **5 years or older and has asthma**.
- Has other **underlying medical conditions** that can put people at higher risk of serious flu complications (such as **lung disease, heart disease, kidney disease, kidney or liver disorders, neurologic or neuromuscular or metabolic disorders**).
- Has had **Guillain-Barré Syndrome** within 6 weeks after a previous dose of influenza vaccine.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

For some patients, a different type of influenza vaccine (inactivated or recombinant influenza vaccine) might be more appropriate than live, attenuated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

4 Risks of a vaccine reaction

- Runny nose or nasal congestion, wheezing and headache can happen after LAIV.
- Vomiting, muscle aches, fever, sore throat and cough are other possible side effects.

If these problems occur, they usually begin soon after vaccination and are mild and short-lived.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

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