Whitney Young has a School-Linked Mobile Unit at Lansingburgh Schools!

What does this mean for you?

- You fill out the attached health questionnaire and consent form to enroll. Please include insurance information.
- Anyone can be seen on the mobile unit. Call 833-6900 for an appointment.
- Your child can receive immunizations for school and the flu shot.
- Your child can use the mobile for sick visits when they are not feeling well.
- If Whitney Young is your Primary Care Provider we can give your child a physical and help you manage your child's health conditions, such as asthma.
- You can come to appointments with your child.
- Your child is enrolled as long as they attend Lansingburgh Schools or you choose to un-enroll.
- Patients without insurance will be billed on a sliding scale based on income.
- Whitney Young Health bills for copays.

Please call Whitney Young Health at 518-833-6900 with any questions.

Knickerbacker Middle/Lansingburgh High – Monday, Wednesday and Friday

Turnpike Elementary – Tuesday

Renesslaer Park Elementary - Thursday

WHITNEY YOUNG HEALTHCARE DESIGNED AROUND HEALTH

I am not interested in signing my child up for mobile health unit services at this time.

Child's Name: _____

Do not fill out form.

MOBILE UNIT CONSENT FOR HEALTH SERVICES

The following services will be provided to you and/or your child on the Whitney Young Mobile Unit:

1. Comprehensive Physical Exams
2. Age appropriate immunizations
3. Assessment and treatment for acute and chronic conditions, minor injuries and emergency care
4. Prescriptions
5. Referrals to outside specialists

I hereby give consent for MY CHILD, _____ to receive health care services provided by the professional staff of the Whitney M Young Health Center Mobile Unit.

- I further give consent to the staff of the Mobile unit to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, you may contact our family physician or any health care providers to share information regarding my or my child's treatment. You may exchange medical information as needed with the school nurse for coordination of care.
- I further give consent to the staff of the Mobile Unit to obtain copies of my child's most recent physical exam and immunization records from their Primary Care Provider.
- I authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier for services rendered by Whitney M Young Jr. Health Center.
- I understand if my insurance coverage does not permit Whitney Young Health to be reimbursed for the care provided, I am responsible for payment to WYH for services rendered.
- I understand that when necessary every effort will be made to contact me for any treatment that requires parental consent according to New York State law. New York State Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, and reproductive health or outpatient mental health services.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms I have received a copy of Whitney M. Young Jr. Health Services Privacy Practices, as well as the Patient Bill of Rights and Patient responsibilities.

Signature: _____ Date: _____

Relationship to Patient: _____

FORM MUST BE SIGNED FOR CHILDREN TO RECEIVE SERVICES ON THE MOBILE UNIT
SIGNED FORMS ARE VALID AS LONG AS THE STUDENT REMAINS IN THE LANSINGBURGH CENTRAL SCHOOL DISTRICT

WHITNEY YOUNG HEALTH

SCHOOL-LINKED HEALTH PROGRAM HEALTH QUESTIONNAIRE
FORM MUST BE COMPLETED & SIGNED EVERY YEAR

PATIENT INFORMATION			
Today's Date:	Student's Last Name: Student's First Name:		Grade: Teacher:
Student's Birth Date: Student's Age:	Name of Parent/Legal Guardian: Parent/Legal Guardian Birth Date:		Relationship to Student:
Sex: M F	Primary Phone #: Secondary Phone #:	Street Address: City:	State: Zip:

Student's Race (circle all that apply): Asian Native American Other Pacific Islander Black/African American

American Indian/Alaskan Native White More than one Race Unreported/Refused to Report

Student's Ethnicity (circle one): Hispanic Latino Non-Hispanic Non-Latino

Language Spoken: _____

INSURANCE

Does your child have insurance? ❑ Yes ❑ No ❑ Need help getting insurance

If yes, please circle all that apply:

Commercial Medicaid Medicare Other Insurance: _____

Primary Insurance Company:	Card Holder's Name:	Group #:	Policy #: SEQ #:
Secondary Insurance Company:	Card Holder's Name:	Group #:	Policy #: SEQ#:

**If your insurance coverage does not permit Whitney Young Health to be reimbursed for the care provided, you agree to pay WYH for any services rendered.

PRIMARY CARE INFORMATION

Student's Primary Care Physician (Pediatrician): _____

Phone # _____

Date of Last Physical: _____ ❑ I have included a copy of my child's most recent physical

IN CASE OF EMERGENCY

We require the name, address, phone number and/or cell phone number of 2 contacts who can be called if you are unavailable.

(Name of contact)	(Relationship)	(Address)	(Phone and/or Cell #)
(Name of contact)	(Relationship)	(Address)	(Phone and/or Cell #)

Signature of Parent/Guardian: _____ Date: _____

BOTH SIDES OF FORM MUST BE COMPLETED EVERY YEAR

Turnpike **Rensselaer Park** **Knickerbacker** **Lansingburgh High**

Please list below ANY medications that your child takes on a regular basis (inhalers, sprays, pills, etc.)			
Medication	Dosage	When do they take it	Why do they take it

Does your child have ANY allergies? ❑ Yes ❑ No
If yes, please list and explain the reaction: _____

Does your child have ANY serious illnesses or medical conditions? ❑ Yes ❑ No
If yes, please explain and provide most recent date: _____

Has your child had ANY serious injuries or accidents? ❑ Yes ❑ No
If yes, please explain and provide most recent date: _____

Has your child had ANY surgery? ❑ Yes ❑ No
If yes, please explain and provide most recent date: _____

Has your child EVER been hospitalized overnight? ❑ Yes ❑ No
If yes, please explain and provide most recent date: _____

Does anyone in the family smoke? ❑ Yes ❑ No
Please explain: _____ ❑ Inside ❑ Outside

Does your child use a seatbelt and/or a booster seat? ❑ Yes ❑ No

Is your child taking a multivitamin? ❑ Yes ❑ No

Does your child seem to get along well in school? ❑ Yes ❑ No
Please explain: _____

What extracurricular activities does your child participate in?
_____

How are your child's grades? ❑ A's and B's ❑ B's and C's ❑ C's and D's ❑ D's and below

Are there any concerns regarding your child that you would like us to be aware of? ❑ Yes ❑ No
Please explain: _____

The staff of the Mobile School-Linked Program considers parental/guardian involvement essential in keeping children healthy and will encourage each student to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the Mobile Unit to attend appointments with their child.

Parent/Guardian Signature: _____ Date: _____

Relationship: _____ Phone Number: _____

INCOMPLETE FORMS WILL NOT BE ACCEPTED

BOTH SIDES OF FORM MUST BE COMPLETED EVERY YEAR

Turnpike **Rensselaer Park** **Knickerbacker** **Lansingburgh High**

PATIENT BILL OF RIGHTS:

As a patient in a Health Center in New York, you have the right, consistent with the law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the Health Center MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, age, religion, sex, national origin, disability, sexual orientation or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the provider who will be in charge of your care in the Health Center.
6. Know the names, positions and functions of any Health Center staff involved in your care and refuse their treatment, examination or observation.
7. A no smoking facility.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders – A Guide for Patients and Families."
11. Refuse treatment and be told what effect this may have on your health.
12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. Privacy while at the Health Center and confidentiality of all information and records regarding your care.
14. Participate in all decisions about your treatment and care at the Health Center. The Health Center must provide you with a written discharge plan and written description of how you can appeal your discharge.
15. Review your medical record without charge. Obtain a copy of your medical record for which the Health Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. Receive an itemized bill and explanation of charges.
17. Complain without fear of reprisals about the care and services you are receiving and have the Health Center respond to you and if you request it, a written response. If you are not satisfied with the Health Center's response, you may complain to the New York State Health Department by calling 1-800-804-5447.
18. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
19. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the Health Center.
20. The right to appropriate pain assessment and management.

PATIENT RESPONSIBILITIES

Providing patients with the best care possible is a collaborative effort of both provider and patient. In addition to the services, rights and privilege afforded to patients by Whitney Young, patients themselves are also requested to adhere to the following "patient responsibilities" to ensure the best overall health care services.

Provide Information:

- Give completed and accurate medical information to Whitney Young Health Staff on the health questionnaire annually and when staff call for information.
- Provide any change of address or telephone number.

Participate:

- Be involved in your care as a team member with the provider/medical assistant. Ask questions to fully understand your care. It may help to write down your questions prior to care.
- Follow treatment advice given.
- Adhere to all Whitney M. Young, Jr. Health Services rules and regulations.

Appointments and Tips:

- The laboratory services are billed separately and are NOT part of Whitney Young Health School Based Health Center or Mobile Unit. These charges cannot be put on a sliding scale fee.
- Allow your provider 7 business days to complete all forms.
- Allow your provider 3 business days for external prescription refills.

Emergencies:

- For any emergency that is life threatening, e.g. chest pains, shortness of breath, uncontrolled bleeding, CALL 911 or GO TO AN EMERGENCY ROOM IMMEDIATELY.
- Whitney M. Young, Jr. Health Services has coverage 24 hours a day, 7 days a week including holidays at (518) 465-4771. Troy Health Center patients should call (518) 833-6900.
- If Whitney Young is closed for the day, the patient will be transferred to our answering exchange.
- A patient directed to an emergency facility or their designee must contact their primary care provider within 48 hours of the visit to an emergency room or admission to the hospital to coordinate follow up care.