EMERGENCY CONTACT CARD

NYC Department of Education

SCHOOL YEAR 20__ __ - 20 __ __

You can update your contact information online using your NYC Schools Account at schoolsaccount.nyc. Don't have an account? Check out schools.nyc.gov/nycsa.

STUDENT INFORMATION

Student Last Name ____ **Student First Name** ____ **M.I.** ____

Date of Birth (mm/dd/yyyy) ____ OSIS ID # ____

If you have filled out the information in NYCSA:

- ❑ **Emergency contact information is correct in NYCSA. No need to update form.**
- ❑ **Updated emergency contact information is below.**

This Guardian Can : ___ Be Contacted in Emergencies ___ Pick Up Student ___ Receive School Mailings (check all that apply).

Parent/Guardian Last Name (Student resides with) ____ **Parent/Guardian First Name** ____ **Relationship** ____

Parent's Preferred Language of Communication (Written) ____ Parent's Preferred Language of Communication (Oral) ____

Home Telephone ____ Work Telephone ____ Cell Phone ____ OK to Text Y | N

Email ____

Address (House Number) ____ Apartment # ____

City ____ State ____ Zip Code ____ Borough ____

This Guardian Can: ___ Be Contacted in Emergencies ___ Pick Up Student ___ Receive School Mailings (check all that apply).

Secondary Parent/Guardian Last Name ____ **Secondary Parent/Guardian First Name** ____ **Relationship** ____

Secondary Parent/Guardian's Preferred Language of Communication (Written) ____ Secondary Parent/Guardian's Preferred Language of Communication (Oral) ____

Secondary Home Telephone ____ Secondary Work Telephone ____ Secondary Cell Phone ____ OK to Text Y | N

Secondary Email ____

Secondary Address (House Number) ____ Apartment # ____

City ____ State ____ Zip Code ____ Borough ____

EMERGENCY CONTACTS

List below names of three additional people who may be called in case of emergency or if child is sick in school.

CHILD WILL BE RELEASED ONLY TO PEOPLE NAMED ON THIS CARD.

Name	E-mail	Telephone	Relationship

IMPORTANT – PLEASE COMPLETE NEXT PAGE >>>

Updated: August 2021

NO ACCESS

If there is a person who may **NOT HAVE ACCESS** to child, please indicate:
Please submit a copy of the order of protection to your child's school.

Name	Relationship	Order of Protection Exists?	Effective Date of Court Order
		☐ Yes ☐ No	

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

☐ Allergist/Immunologist ☐ Cardiologist ☐ Dermatologist ☐ Development/Behavioral Specialist
☐ Neurologist ☐ Pulmonologist ☐ Other _____

Health Alert

Does child have any health condition that may affect participation in physical activities? ☐ Yes ☐ No

Limitations _____
(e.g., stair climbing, participation in gym)

Known Diagnoses (please check all that apply)

☐ Asthma ☐ Seizures ☐ Allergies/Anaphylaxis ☐ Diabetes ☐ None ☐ Other _____

Allergies (select all that apply)

☐ Milk ☐ Eggs ☐ Peanuts ☐ Tree Nuts (Other Nuts) ☐ Fish
☐ Shellfish ☐ Soy ☐ Wheat ☐ Other _____

My child has (X any that apply): ☐ Private health insurance ☐ Medicaid ☐ No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? ☐ Yes ☐ No

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

Sibling's Last Name	Sibling's First Name	Sibling's School of Attendance

SIGNATURE OF PARENT/GUARDIAN

☐ By checking this box, I agree to be contacted by elected School, District, and/or City-wide parent leader volunteers regarding events, updates, and other matters connected to my school community.

☐ By checking this box, I agree that my contact information can be shared with elected School, District, and/or City-wide parent leader volunteers so I can be updated on events and other matters connected to my school community.

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

FOR OFFICE USE ONLY

To be completed by school staff only.

Grade _____ Class _____ Room No. _____ Teacher _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

Date	Contact	Reason	Disposition

CONSENT FORM FOR COVID-19 TESTING

What is this form?

We are seeking your consent to test your child for COVID-19 infection. The New York City Department of Education (NYC DOE) working with NYC Health + Hospitals and the New York City Department of Health and Mental Hygiene, has partnered with laboratories and other providers to test NYC DOE students, teachers, and staff members for COVID-19 infection.

How often would you test my child?

Our laboratory and provider testing partners will come to every school periodically to test some of the students, teachers, and staff. If you consent, your child may be selected for testing on one or more of these occasions, and your child may also be tested (1) in accordance with state and city mandates, or (2) if they exhibit one or more symptoms of COVID-19, or (3) if they are a close contact of a student, teacher, or staff person with COVID-19 infection, or (4) in connection with their participation in an extracurricular activity for which testing may be conducted.

What is the test?

If you consent, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose and/or collecting saliva (spit).

How will I know if my child tests positive?

If your child has a specimen collected for testing, we will send information home with them to let you know. COVID-19 test results will generally be provided within 48-72 hours.

What should I do when I receive my child's test results?

If your child's test results are positive, please contact your child's doctor immediately to review the test results and discuss what you should do next. You must keep your child at home and should inform your child's school. If your child's test results are negative, this means that the virus was not detected in your child's specimen. Tests **sometimes** produce incorrect negative results (called "false negatives") in people who have COVID-19. If your child tests negative but has symptoms of COVID-19, or if you have concerns about your child's exposure to COVID-19, you should call your child's doctor. If you need help finding a doctor, call (844) NYC-4NYC.

TO BE COMPLETED BY PARENT, GUARDIAN, OR ADULT PARTICIPANT

PARENT/GUARDIAN INFORMATION

Parent/Guardian (Print Name): _____

Parent/Guardian Address: _____

Parent/Guardian Tel./Mobile #: _____

Parent/Guardian Email address: _____

Best way to contact you: _____

CHILD INFORMATION

Child (Print Name): _____

Child School ID/OSIS # (if known): _____

Child Date of Birth: _____

Child Home Address: _____

NOTIFICATION OF INFORMATION SHARING

The law allows some information about your child to be shared with and among certain New York City and New York State agencies and their contracted service providers, including those listed below. This information will be shared only for public health purposes, which may include notifying close contacts of your child if they have been exposed to COVID-19, and taking other steps to prevent the further spread of COVID-19 in your community. Information about your child that may be shared with these agencies and service providers conducting COVID-19 Testing includes your child's name and COVID-19 test results, date of birth/age, gender, race/ethnicity, school name(s), teacher(s), cohort/pod, enrollment and attendance history, afterschool or other extracurricular program participation, names of other family members or guardians, address, telephone, mobile number, and email address. Sharing of information about your child will **only** be done in accordance with applicable law and City policies protecting privacy and the security of your child's data.

1. NYC Department of Education
2. NYC Department of Health and Mental Hygiene
3. NYS Department of Health
4. NYC Department of Youth and Community Development
5. NYC Health and Hospitals Corporation
6. Contracted Service Providers for COVID-19 Testing

CONSENT

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child may be tested at multiple times through September 30, 2022, and that testing may occur (1) on days scheduled by the NYC DOE in accordance with the testing program or state and city mandates, or (2) if they exhibit one or more symptoms of COVID-19, or (3) if they are a close contact of a student, teacher, or staff person with COVID-19 infection, or (4) in connection with their participation in an extracurricular activity for which testing is recommended (for example, sports).

- I understand that this consent form will be valid through September 30, 2022, unless I notify the designated contact person from my child's school **in writing** that I revoke my consent.
- I understand that my child's test results and other information may be disclosed as permitted by law.
- I understand that if I am a student age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.

Signature of Parent/Guardian: _____ Date: _____

(if child is under age 18)

Signature of Student: _____ Date: _____

(if age 18 or over or otherwise authorized to consent)

Mount Sinai Adolescent School Based Health Center Parental Consent Form

Martin Luther King Jr. High School Campus

122 Amsterdam Ave, Room 203, NYC 10023
212-501-1276

Name of School(s): **Maxine Greene HS ( ) Urban Assembly Media HS ( ) HS of Law & Advocacy and Community Justice ( )**
Arts & Tech HS ( ) Special Music School ( ) Manhattan Hunter Science HS ( )

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 Mount Sinai Adolescent _ 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 _____ _____
Signature of Parent/Guardian **Date**

Mount Sinai Adolescent 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 Mount Sinai Adolescent Health Center 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 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 MOUNT SINAI ADOLESCENT 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

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

NYC Department of Education

Media Consent for NYC Department of Education Use

Student Name: _____

School: _____

I consent to the use and disclosure of the image, quotes, name, the participation in interviews, and the taking of photographs, recordings, and videos of the Student named above by the New York City Department of Education (**NYC DOE**) and NYC DOE-invited members of the press for NYC DOE-sponsored events. I grant the NYC DOE and invited members of the press the right to disclose, edit, use, and reuse the Student's image, quotes, name, and interviews, and photographs, recordings, and videos of the Student for the NYC DOE's nonprofit and public press purposes. This includes use in print, on broadcasts, in online spaces (such as the NYC DOE website and social media accounts and those of the press), and all other forms of media. I understand that when the school hosts a public event, individuals at the event may take their own photographs, videos and audio of the event, that such recordings may capture me or my child, and that they may also be made public.

I also release the NYC DOE, its agents, and employees from all claims, demands, and liabilities in connection with the rights granted above.

If Student is Under Age 18:

Name of Parent / Guardian: _____

Signature of Parent / Guardian: _____

If Student is Age 18 of Over:

Name of Student: _____

Signature of Student: _____

Date: _____

For students age 18 and over, the form must be signed by the student, and not the parent or guardian.

Department of Education

Chancellor's Regulation A-101
Housing Questionaire

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. The district cannot disclose housing status information without parental consent.

Student Name & Information:

Last Name	First Name	Middle Name

OSIS Number	Date of Birth (MM/DD/YY)	School

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

Check (√)	Housing 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
○	**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:

☐	**Unaccompanied Youth -** Youth who is not in the physical custody of a parent or guardian	(School Use Only) Enter "Y" if Applicable

Parent/Guardian (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. Please refer to Chancellor's Regulation A-780.

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

CONSENT FOR USE OF ELECTRONIC MAIL

Dear Parent/Guardian:

The New York City Department of Education recognizes that electronic mail (email) is a valuable communication tool. It is the intention of the High School for Law, Advocacy & Community Justice to communicate and work together with the parents and guardians of the students that we serve. Recently, the use of e-mail has become an excellent tool for two way and convenient communication between parents and teachers.

To remain compliant with the Family Educational Rights and Privacy Act (FERPA) and the The Individual with Disabilities Improvement Act (IDEA), confidential written notices (including grading, attendance, discipline information, notices of recommendations, procedural safeguards notices and notices related to due process complaints) can only be transmitted by electronic mail (email) with the written consent of the parent or guardian.

In order for school personnel to use the internet email system for transmission of notices to you, a signed consent form must be on file with the school. If you would like to receive notices via email please sign this consent form.

I hereby give consent to receive emails from the school concerning my child:

Type your name and sign below