NYU LANGONE HOSPITALS
HEMPSTEAD HIGH HEALTH CENTER
201 President Street Hempstead, NY 11550
(516) 434-4251
A Joint Program of the Hempstead School District and NYU Langone Hospital – Long Island
Student Self Consent for Health Services

Please know that you 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 you can see your private doctor.

STUDENT INFORMATION

Student Last Name: _____

Student First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female **Grade**:_____

Student Address:_____
_____:
City State Zip Code

Student Cell: _____

Student email :_____

Ethnicity: ❑ Hispanic ❑ Black ❑ White
❑ Asian/Pacific Islander ❑ Other _____

***Student Social Security Number:** _____

(*optional field: Used for insurance purposes only)

Do you have a regular doctor? □ No □Yes , please list here
Name: _____
Telephone: _____
Address: _____

EMERGENCY CONTACT INFORMATION ONLY

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: _____

Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Last Name:_____ First Name:_____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

Indicate the Pharmacy where we can send prescriptions
Pharmacy Name_____
Pharmacy Address: _____
Pharmacy Tel: _____

INSURANCE INFORMATION

Do you have Medicaid OR Child Health Plus? ❑ **No** ❑ **Yes**

Medicaid ID # _____ CHP # _____

Do you have other Insurance? ❑ **No** ❑ **Yes**

Insurance Name:_____ Insurance ID#_____

STUDENT CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

The School Based Health Center has explained to me the scope of the Health Services that I may receive.
I have read and understand the services listed above and my signature provides consent to receive confidential health services provided by Hempstead High School-Based Health Center.

_____ _____
Signature of Student **Date**