JEWISH RENAISSANCE MEDICAL CENTER, Inc.

Executive Office:
275 Hobart Street • Perth Amboy, NJ 08861
(732) 376-9333 • Fax: (732) 293-0139

Dear Parent/Guardian:

Before the rush of the new school year begins, the Jewish Renaissance Medical Center encourages you to register your children for our School-Based Health Center located at:

Thirteenth Avenue/Dr. MLK Jr. School
359 13th Avenue, Newark, NJ 07103
973-679-7709
Please press 3 for a listing of all locations & then press 7 for 13th Ave

Access to the medical services we provide has been shown to increase student engagement in schools, academic performance, and improve overall health. Our School-Based Health Center is extremely convenient for parents/guardians. **Once your child is registered, we can provide them with health care without requiring you to miss work or other obligations; or your child having to miss school.** Our services include but are not limited to:

- Annual physicals, sports physicals, immunizations, sick visits, and asthma treatments
- Dental services that include screenings, cleanings, fillings, x-rays, and simple extractions
- Mental health services that include teen counseling, and youth mental wellness

Patients who are uninsured may qualify for Presumptive Eligibility (temporary Medicaid) or Charity Care. Program eligibility is based on your gross household income and household size. We accept most forms of health insurance, including Medicare, NJ FamilyCare, and commercial/private insurance and self-pay.

Please take advantage of these services by first filling out the Registration Form and the Parent Consent Form included in this packet. After the initial visit, we will contact you for additional required information. The completed materials should be returned to Michele Levy, our Health Center's registrar, at 13th Avenue School. Materials can also be returned to the 13th Aveneue School Nurse's Office upon completion. We request that parents complete these forms as soon as possible to ensure coverage of their children for the upcoming school year.

We look forward to working with you to determine and realize the health & wellness objectives for your child. Any further questions or information, please contact Michele Levy at the number indicated above. Thank you.

Sincerely,

Dr. Kafilat Adewunmi, D.O/MBA
Clinical Director
Newark School-Based Health Center Program

JEWISH RENAISSANCE MEDICAL CENTER
(973) 679-7709 – Seven (7) locations; Family Practice at Central, Park and 13th Avenue

REGISTRATION FORM (PLEASE FILL OUT COMPLETELY)

PATIENT INFORMATION — TODAY'S DATE:_____

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____ **DOB: (M/D/Y):**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP CODE:**_____

SOCIAL SECURITY #:_____-_____-_____ **MARITAL STATUS:**_____

Sexual Orientation: [ ] Lesbian or gay [ ] Straight (not lesbian or gay) [ ] Bisexual [ ] Something else [ ] Don't know [ ] Choose not to disclose
Gender Identity: [ ] Male [ ] Female [ ] Transgender Male/Female-to-Male [ ] Transgender Female/Male-to-Female [ ] Other [ ] Choose not to disclose

HOME #:_____ **MOBILE #**_____ **EMAIL:**_____

DATA SURVEY - In an effort to comply with requirements regarding federal record-keeping and reporting, we ask that you complete the following data survey. Your cooperation is appreciated.

PRIMARY LANGUAGE: [ ] English [ ] Spanish [ ] Other:_____ **INTERPRETER NEEDED?:** [ ] Yes [ ] No

IS YOUR PRIMARY RESIDENT CONSIDERED PUBLIC HOUSING [ ] Yes [ ] No **FAMILY SIZE:**_____

ETHNICITY	RACE	SPECIAL POPULATION	ANNUAL INCOME RANGE
□ Hispanic (Latino)	□ Black (African-American)	□ Migrant	□ 0 - $11,880
□ Non-Hispanic (Latino)	□ White	□ Seasonal	□ $11,881 - $17,820
□ Unreported/Refused	□ Asian	□ Homeless Shelter	□ $17,821 - $23,760
	□ American Indian/Alaska Native	□ Transitional	□ $23,761 - $29,700
	□ Native Hawaiian	□ Doubling Up	□ $29,701 - $35,640
	□ Other Pacific Islander	□ Street	□ $35,641 +
	Multiracial – select 2 from above	□ Other	
	□ Unreported	□ Unknown	

RESPONSIBLE PARTY

SOCIAL SECURITY #:_____-_____-_____ **RELATIONSHIP TO PATIENT:**_____

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____ **DOB (M/D/Y):**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP CODE:**_____

HOME #:_____ **MOBILE #**_____ **EMAIL:**_____

INSURED INFORMATION

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____ **DOB (M/D/Y):**_____

EMPLOYER:_____ **TELEPHONE #:**_____

INSURANCE:_____ **POLICY #:**_____ **GROUP #:**_____ **EFFECTIVE DATE:**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP CODE:**_____

INSURANCE TELEPHONE #:_____ **RELATIONSHIP TO PATIENT:**_____

EMERGENCY CONTACT

NAME:_____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP CODE:**_____ **PHONE #:**_____

SIGNATURE: I certify that the information provided is correct:_____

JRMC USE ONLY - Patient Account #:_____ **Unit Clerk Initials:**_____ **Date:**_____

JEWISH RENAISSANCE MEDICAL CENTER
NEWARK SCHOOL-BASED HEALTH CENTERS

PARENT CONSENT FORM

I understand that the goal of the school-based health program is to improve the health and well-being of the children by providing onsite **MEDICAL, DENTAL & COUNSELING** services. These services will be provided by a staff of doctors, nurse practitioners and other health care professionals with expertise in child and adolescent health care. The Jewish Renaissance Medical Center of Perth Amboy, NJ employs these staff members. Services are available to **ALL** minors 0-17 years of age with parental consent.

I,_____ give consent for my son / daughter _____
Parent / Guardian Child's Name

To receive the services listed below:

Primary and Preventive	Counseling Services	Dental Services
1. Physical exams	1. Individual, family and group counseling	1. Examinations
2. Treatment of minor illness	2. Crisis intervention	2. X-rays
3. Immunizations	3. Psychosocial Assessments	3. Cleaning and Fluoride
4. Follow-up medical care	4. Psychiatric intervention to include assessments, treatment and medication if indicated	4. Dental Sealant
5. Health and Nutritional Counseling		5. Restorative
		6. Extractions
		7. Local anesthetic to numb area

Please list any services you do not wish your child to receive _____

- I understand that all medical information will be kept strictly confidential and records will not be released without my written permission. I understand that by signing this consent form I give permission for my child to be seen at the health center without my being present. However, should I choose to, I can be present.
- I give permission for the health center staff to have access to my child's school health records through the nurse's office. I understand that my child may be referred to other medical and community-based resources for services that are not provided at the school-based health center.
- I understand that there will be a minimal charge for these services. However, if I have insurance, my insurance carrier will be billed first for services rendered.

Special Services

If my child is an adolescent, I understand that by law my consent is not necessary for "special services." For these "special services", I understand that confidentiality between the health center and the student will be maintained. However, students will be encouraged to involve their parent / guardian in decisions about their health care, including the provision of special services.

In addition, I _____ the mother/father or legal guardian of _____ do hereby give the Jewish Renaissance Medical Center and its providers' permission to examine and treat my child without a parent/guardian being present at appointments.

I certify that I have read this consent form and I understand it and that it is my wish to enroll my child in the school-based health program operated by the Jewish Renaissance Medical Center for the length of time that my child attends the Newark Public / Charter / Vocational Schools.

_____ _____
Signature of Parent / Guardian Date

Please list a phone number and indicate the best time for health center staff to contact you in order to inform you of your child's medical care:

Daytime Phone #:_____ Time:_____ Alternate Phone #: _____

If necessary, I give the following individual(s) permission to accompany my child to their office visit in my absence (person must be 18 or older). I understand that photo identification will be required and a copy will be made and placed in my child's file as documentation.

Name:_____ Relationship to child:_____ Phone #_____

Name:_____ Relationship to child:_____ Phone #_____

PLEASE COMPLETE THE REGISTRATION FORMS – THANK YOU!

Newark School Based Health Center (NSBHC)

LOCATIONS

NORTH WARD

Barringer High School
90 Parker Street
Main Entrance
Newark, NJ

Park Elementary School
120 Manchester Place
Newark, NJ

WEST WARD

13th Avenue/Dr. MLK Elementary School
359 13th Avenue
Entrance at S. 8th Street
Newark, NJ

CENTRAL WARD

Central High School
246 18th Avenue
Entrance at Boyd Street
Newark, NJ

Quitman Street Community School
21 Quitman Street
Main Entrance
Newark, NJ

SOUTH WARD

Malcolm X Shabazz High School
80 Johnson Avenue
Entrance at Milford Avenue
Newark, NJ

George Washington Carver Elementary School
333 Clinton Place
Forest Place Entrance
Newark, NJ

Our Services

Our professionals are experienced doctors, dentists, clincial social workers, and other medical professionals who share the unique blend of proven experience as clinicians while sharing the compassion to provide the highest quality of care for all!

Additional benefits include:

- No need for your child to miss school or for you to miss work to be sure your child's health is addressed.
- No need to change your own doctor, dentist, or social worker - we will still care for your child without having to go through prolonged adjustments with your insurance.

MOBILE UNIT

The full continuum of our care is mobile!

Got Questions?

Call us at: (973) 679-7709
Navigator Program: (973) 564-1415
For Free Health Care Assistance: (973) 564-1415
newarkhealthcenters@jrmc.us

For More Information:
Visit our website: *jrmc.us/where-we-work/nsbhc/*