NJ School Based Youth Services Program (SBYSP)
Evaluation Consent Form

Student School ID#:-----------------------------------

Dear Parent or Guardian:

The New Jersey Department of Children and Families (DCF), Division of Family and Community Partnerships (FCP), Office of School Linked Services (OSLS) is pleased to continue supporting the NJ School Based Youth Services Program (SBYSP – **Atlantic City Teen Center**) that is available to your high school child.

The NJ SBYSP began in 1987 and continues today with the goal *to help young people navigate their adolescent years, finish their education, obtain skills leading to employment or continuing education, and graduate healthy and drug free.*

When you consent to your child's participation in the NJ SBYSP you are committing to your child's ultimate goal of graduating high school. The SBYSP is available in 67 high schools and it is important that we continuously ensure the programs are achieving its goal. As a result, each program is required to use the following two tools to determine their impact. The two tools contain less than 15 questions related to your child's thoughts about the program and/or their role in achieving their high school graduation goal.

- The NJ SBYSP High School Impact Evaluation will be provided anonymously to students that participate in a program activity during the months of October and March.
- The Self-Efficacy Assessment Tool will be provided to students that have participated in at least 2 individual counseling appointments within a 30 day period.

When reports are produced **individual students names will not** be mentioned.

Students are not required to complete the evaluation, this is truly voluntary. A participant also has the right to discontinue participating at any point. No action will be taken against the school, you, or your child, if your child does not take part. This consent is valid for your child's entire Atlantic City High School academic career unless revoked in writing by contacting the Teen Center at Atlantic City High School.

As a parent/guardian you can review a blank copy of these two tools by contacting the SBYSP directly or under "Guidance" on the website www.acboe.org under Teen Center. If you would prefer your child not participate with these evaluations please indicate so on the reverse side under opt out section #6 Consent for Social Services.

Thank you

AtlantiCare Atlantic City Teen Center Social Services
RIGHTS and CONSENT

CLIENT NAME:________________________________ CASE NO (Office Use) .:_______________
DOB: _________________________ GENDER: M F GRADE: ___________
HOME PHONE NO.: _______________________ EMERGENCY PHONE NO.: _______________________

The objective of the School Based Youth Services program is to promote healthy adolescent development and to assure that adolescents can obtain support and assistance in an accessible location. The goal of the program is to provide a comprehensive array of services to adolescents at their school. These services include: health and social services, employment, recreation, counseling, educational workshops and family life education.

Client Rights for Social Services

You have a right to:

1. Reasonable access to considerate, empathetic and respectful care by competent staff.
2. Receive care regardless of race, religion, sex, national origin, age disability, life-style or ability to pay
3. Informed consent to participate in, or refuse, any service
4. Information regarding your needs and services be kept confidential and your personal privacy and dignity respected.
5. Request to refuse the release of information regarding your services or records, unless otherwise required by law.
6. Present complaints and receive a response within a reasonable time period.
7. Receive SBYSP services free of charge.

Consent for Social Services

1. I grant permission to ABH to inquire about my needs for the purposes of providing social services. I consent to such services as provided by ABH staff and/or staff contracted by ABH to provide services. I understand that this consent applies to this, and all subsequent visits, unless I revoke my consent.
2. If the client named above cannot understand his/her rights and provide such consent, then a parent/guardian is informed of those rights and signs for the client.
3. I have discussed with ABH staff my reason(s) for seeking services and I acknowledge that no guarantees have been made to me concerning access to ongoing care, receipt of services or outcomes. I understand my responsibility to provide complete and accurate information concerning my needs for services.
4. In general, confidentiality of all communication between ABH staff and me for all services is protected by ABH ethical standards and will be released only with my written permission. I understand that there are times when information can be released without my permission in accordance with Federal laws and state regulations, including if I threaten to seriously hurt myself or someone else or if physical or sexual abuse of a child is disclosed.
5. With this consent, ABH staff or representatives may disclose all or part of my records consistent with state and county laws and regulations.
6. All services are voluntary. Students and families may use as many, or as few, services as desired. While I consent to having ABH staff provide services to my child, I do not want my child provided with or to participate in the following services: ____

____ ______________________
Client Signature Date

____ ______________________
Parent/Guardian Signature (**if needed**) Date

____ ______________________
Signature/Title of Staff Completing Form Date

____ ______________________
Signature/Title of Supervisor (Official Use) Date

SBYSP CLIENT REGISTRATION

1. ______________________________ ________ ______________________________
First Name MI Last Name

2. a. Street Address:

3. (_______) ___________-____________

b. ___________________________ ________________ ___________________
City State Zip Code

Emergency Contacts: Who should we contact in case of emergency:

4. a. What is the name of Contact #1

____

4. b. Daytime phone number for Contact #1?

(______) __________-____________

5. a. What is the name of Contact #2

____

5. b. Daytime phone number for Contact #2?

(______) __________-____________

6. How are Contacts #1 and #2 related to you? (Circle and Mark #1/#2)

____Mother/Step Mother ____Father/Step Father ____Grandparent ____Sibling
____Aunt/Uncle ____Boyfriend/Girlfriend ____Cousin ____Husband/Wife
____Friend/Schoolmate ____Other: ________________

7. Who's idea was it for you to come to this Teen Center? (Circle One)

Mine (Client's) Parent/Stepparent Teacher Other Family Member
Friend/Classmate Guidance Staff School Nurse
Juvenile Justice System Human Services Agency
Someone Else:_____________________ Other School Staff:_________________

8. Birth Date:

________/________/________

9. Sex: (Circle One)
F Female
M Male

10. Ethnicity: (Circle all that apply)
American Indian/Alaska Native
Black/African American
Hispanic/Latino
White-non-hispanic
Asian American
Native Hawaiian/Other Pacific Islander
Other_____________________________

School enrollment

11. Are you currently enrolled in school? Y / N
12. If Yes what is your current grade? ___________________________
13. If NO, what is the last grade completed? ______________________

14. What adults do you live with right now? (Circle all that apply)

No Adults Mother Father Step Mother Step Father Grandmom Granddad Other

15. What type of medical insurance do you have?

Medicaid FamilyCare Private Other None Don't know

FOR OFFICIAL USE ONLY

Registration Date:

_____/______/_____

Client ID:

____

Other ID:

____

Form: New/Revised

____

Consent Date:

_____/______/_____

Consent on file
(circle one)

X None
L Limited
U Unlimited

Risk groups
(circle all that apply)

DO
PR
TR
AD
FC
SA
DS
IJJ
AA
SX
PA
EAT
HL

I hereby grant permission to AtlantiCare, its employees and assigns and/or outside media to photograph, videotape or interview me and/or my dependent(s) on various dates throughout AC Teen Center services prorams. The specific information AtlantiCare can releases to traditional and new media and through other AtlantiCare communications channels includes:

_____Photos/Video _____Story/Testimonial _____Interview _____Other, describe:

____

I understand that the photographs, video, audio, or interview shall become the property of AtlantiCare and/or outside media and organizations and that I shall not have any rights to the same. I also understand that I will not be compensated for participating in the taking of photographs; video, audio and other recordings; or interviewing and that I will not be entitled to compensation as a result of the broadcast or publication of the information.

I understand that the photographs, video or interview may be used and redisclosed as a press release and shared with media for possible publication or broadcast. I also understand that the photographs; video; audio and other recordings; and/or interview might be publicized or broadcast, or used in promotional and informational materials that include, but are not limited to, brochures, billboards, advertisements, the AtlantiCare Internet and Intranet sites, Facebook and any and all other social media and traditional media and publicity and marketing and communications venues. I understand that the information, photographs, audio, video, and/or interview might be edited and I agree that AtlantiCare, its employees and/or agents shall have the right to, at any time, add to, edit, arrange, rearrange and/or revise such information, photographs, video or interview. I understand that AtlantiCare maintains the right to reuse the information, photograph, video, or interview for future purposes without additional authorization or release.

I release AtlantiCare, its employees and agents from any and all claims and from all liability including, without limitation, claims for libel, invasion of privacy and/or misappropriation of likeness arising out of the interviewing, photographing or videotaping and subsequent publication or broadcasting of this material. I understand that I am not required to sign this authorization and that AtlantiCare will not condition treatment on my execution of this authorization. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with the request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations and that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA. This authorization will expire September 1, 2072.

Name (please print): ____

Please circle one:

Employee	Patient	ABH AC Teen Center Group/Program Member

Signature: ____

If Subject is a Minor (under the age of 18):
Name of Parent or Guardian (please print):____

Signature: ____

Office Use Only
Description:____

____

AtlantiCare Photo-Media-Release of Information Form – Nov. 2020.

If the patient requests a doctor's appointment and is a *minor* (meaning under the age of 18 years) a guardian/representative must sign the highlighted areas below.

PATIENT NAME:

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) am suffering from a condition requiring treatment, I voluntarily consent to such care. I consent to routine diagnostic procedures, x-rays, and to medical treatment by providers in AtlantiCare and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating provider. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare. Patients at AtlantiCare will be treated regardless of race, color, age, national origin, disability or religion.

Signature of patient or patient representative:________________________________ Date from: ________to: **12/31/_____**

Representative's relationship to patient:______________________________Witness:___________________________

Patient is unable to consent because: ____

Acknowledgement of Privacy Practice: I understand and have been provided with AtlantiCare's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

Signature of patient or patient representative: _______________________________________Date from: ________ to: **12/31/____**

General Terms and Conditions:

1. I understand that as a part of my healthcare, AtlantiCare originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. This information is used as described in the Notice of Privacy Practices and to: plan my care and treatment, communicate with professionals involved in my care, and routine operations such as audits reporting requirements, utilization review, and quality assessment activities.
2. I am aware and have been advised that I (or the patient) am suffering from a condition requiring treatment and I am presenting myself for treatment and I voluntarily consent to such care. I consent to diagnostic procedures and medical treatment by providers at AtlantiCare's medical staff and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare.
3. AtlantiCare maintains patient medical records in paper, microfilm and /or electronic media, including photo identification, which may be accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Medical records are disclosed according to applicable New Jersey State Laws, Federal laws 42 & 45 C.F.R. and the provisions of this consent.
4. I hereby assign to AtlantiCare physicians participating in my care and other licensed providers any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold AtlantiCare harmless for any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, pre-certification, prior or retrospective authorization or utilization review of the medical services I receive. I agree that I am financially responsible for deductibles, coinsurance and uncovered services that are not covered by my insurance policy.
5. I certify that the information given by me in applying for payment under titles XVIII and XVIX of the Social Security Act is correct. As acceptable, I certify that I have received the Important Message from Medicare

By signing this consent, I am indicating that I understand the contents of this document and agree to its provisions including the disclosure of information in accordance with AtlantiCare's Notice of Privacy Practices. I am signing this consent voluntarily.

Signature of patient or patient representative: ______________________________________Date from:_______ to: **12/31/____**

Representative's relationship to patient__________________________________Witness:_________________________

Patient is unable to consent because: ____

	Atlantic City Public Schools

Parental/Guardian Consent Form

We are sending you this parental consent form to both inform you and to request permission for your child's photo/image and personally identifiable information to be published on the district and/or school's web site.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, e-mail address, phone numbers and locations and times of class trips.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school.

Check one of the following choices:

- ☐ I/We GRANT permission for a photo/image that includes this student without any other personal identifiers to be published on the school and/or district's public Internet site.
- ☐ I/We GRANT permission for this student's photo/image and name to be published on the school and/or district's public Internet site.
- ☐ I/We GRANT permission for this student's photo/image and all other personal identifiers listed above to be published on the school and/or district's public Internet site.
- ☐ I/We DO NOT GRANT permission for photo/image that includes this student to be published on the school and or district's public Internet site.

Student's Name: (please print) ________________________________
Student's Grade: _____
Print name of Parent/Guardian: (print) ____
Signature of Parent/Guardian: (sign) ____
Relation to Student: ____
Date: __________________