**SCHOOL-BASED HEALTH CENTER CONSENT FOR SERVICES**

***Please complete all information in this packet in ink; all questions must be answered. You must sign and date each page in order for your child to receive services from the School-Based Health Center. If this form is not fully completed, your child may not be able to receive services. If a student is 18 or older or emancipated, he/she can sign his/her own permission form.***

**Student's name:**_____ ☐ **Female** ☐ **Male**
**Last** **First** **Middle**

**Address:** _____ **City:** _____ **Zip Code:** _____

**Home Phone** _____ **Birth Date:** _____ **Social Security No.:** _____

**Student Cell #** _____

**Mother/Father or Guardian Name:** _____ _____

**Mother/Father or Guardian Phone #'s** **Work** _____ **Home** _____

**Mother/Father/Guardian Cellular Phone #s:** _____

**Email** _____

**Emergency contact** (please note how the person is related to the student):

| | | | | | |
|---|---|---|---|---|---|
| Contact Name: | | Phone/ Cellular# | | Relation-ship | |
| Contact Name: | | Phone/ Cellular# | | Relation-ship | |

**Racial/Ethnic Background of Student**:

☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

**Ethnicity of Student:**

____ Hispanic/Latino ____ Not Hispanic/Latino ____Other

**Source of Medical Care**:

Who is your child's Doctor/Clinic: _____ Dentist/Clinic: _____
Address & Phone: _____ Address & Phone: _____

**Where do you get your child's medical care?**

☐ Community Health Center ☐ Hospital Clinic ☐ School Based Health Center
☐ Emergency Room ☐ Military Clinic ☐ Urgent Care Clinic
☐ Health Department Clinic ☐ No Regular Source ☐ Unknown
☐ Health Maintenance Organization ☐ Private Doctor ☐ Other Type: _____

*
**Signature of parent/guardian:** _____**Date:** _____

**FOR OFFICE USE ONLY**: **Address Updates:** **Phone Updates:**

_____ _____
_____ _____

**Student Name: _____ Birth Date _____**

## SCHOOL BASED HEALTH CENTER STUDENT INSURANCE INFORMATION

*****IMPORTANT*** Please provide information regarding your child's insurance coverage. The form will be returned if insurance information is not filled in.**

**Type of Insurance (*check all that apply* and complete information below on your child's insurance coverage)**

- ☐ **Medicaid(Title 19)**
- ☐ **Private/Commercial Insurance**
- ☐ **Dental**
- ☐ **No Insurance Coverage**
- ☐ **Medicaid HUSKY A**
- ☐ **Medicaid HUSKY B**
- ☐ **Medicaid HUSKY D**

**MEDICAID (TITLE 19); Medicaid HUSKY A; Medicaid HUSKY B and Medicaid HUSKY D Information:**

Child's Medicaid # _____ Effective Date _____

**PRIMARY INSURANCE INFORMATION:**

Policy Holder's Name: _____ Relationship to Student: _____

Policy Holder's Address: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security #: _____

Insurance Carrier Name and Address: _____

Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____

Effective Date of Coverage: _____

Policy Holder's Employer Name and Address: _____

_____

**Do you have dental insurance?** ☐ **Yes** ☐ **No**

***Please provide a copy of your current insurance card(s), Including your HUSKY card.***

I have read the materials regarding the services of the School Based Health Center including the SBHC privacy notice (available at the SBHC). I give permission to the School Based Health Centers to release information regarding treatment and/or services to my or my child's insurance provider(s) for the purpose of billing. I authorize payments to be made directly to Windham Hospital for services provided.

***Please note: If you do not have insurance at the time you sign this consent, but obtain it later, we will bill your insurance company for services provided using your signature below as authorization to bill.**

_____ _____

**Parent/Guardian Signature** **Date**

_____

**Relationship to Child**

**STUDENT'S MEDICAL HISTORY**

**Student Name:** _____ **Birth Date:** _____

**PAST MEDICAL HISTORY: (please fill in)**

Has your child had any medical problems: _____

1. Chronic problems (asthma, diabetes, ADHD, Mental Health, Etc. _____
2. Disabilities (special ed./medical etc.) _____
3. Has your child ever been hospitalized/had surgery/been injured: _____
4. Childhood illness: (Chicken pox, measles, mumps, rubella, etc. _____

**Has your child had any of the following**: (Please check either "Yes" or "No" for **every** question; if you cannot answer a question please attach a statement explaining why.

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Eating Problems | ☐ | ☐ | Pregnant |
| ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Seasonal Allergies |
| ☐ | ☐ | Sleeping Problems | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Weight Problems | ☐ | ☐ | Headaches |
| ☐ | ☐ | Vision Problems | ☐ | ☐ | Seizures |
| ☐ | ☐ | Hearing Problems | ☐ | ☐ | Blood Disorders (Anemia, Sickle Cell Disease or Trait) |
| ☐ | ☐ | Dental Problems | ☐ | ☐ | Attention Deficit Disorder or ADHD |
| ☐ | ☐ | Skin Disorders (Eczema, Psoriasis) | ☐ | ☐ | Depression |
| ☐ | ☐ | Ear Infections | ☐ | ☐ | Mental Illness |
| ☐ | ☐ | Asthma | ☐ | ☐ | Hernia |
| ☐ | ☐ | Pneumonia | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Tuberculosis (Contact/Infection) | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Heart Problems ( Murmur, Rheumatic, Heart Disease) | ☐ | ☐ | Cancer |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Chicken Pox |
| ☐ | ☐ | High Cholesterol | ☐ | ☐ | Mononucleosis |
| ☐ | ☐ | Stomach Problems (Diarrhea, Constipation, Pain, Vomiting) | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Urinary tract Infections | ☐ | ☐ | Meningitis |
| ☐ | ☐ | Menstrual Problems | ☐ | ☐ | Other: Explain: _____ |
| ☐ | ☐ | Lead / Highest level _____ | | | |

Is your child taking any medications on an every day or frequent basis Yes † No† _____

**Medications can include some of the following: (Please list names)**

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | Aspirin, Ibuprofen or Tylenol? | _____ |
| ☐ | ☐ | Oral Contraceptive/Birth Control pills? | _____ |
| ☐ | ☐ | Antibiotics such as Penicillin, etc.? | _____ |
| ☐ | ☐ | Mental Health or behavioral medications (i.e. ADHD)? | _____ |
| ☐ | ☐ | Vitamins (including iron pills)? | _____ |
| ☐ | ☐ | Asthma Medication? | _____ |
| ☐ | ☐ | Allergy Medication? | _____ |
| ☐ | ☐ | TB Medication? | _____ |
| ☐ | ☐ | Diabetic medications (i.e. insulin)? | _____ |
| ☐ | ☐ | Other medication? | _____ |

Is your child allergic to or have they had an adverse reaction to:

Yes ☐ No ☐ Betadine or iodine
Yes ☐ No ☐ Penicillin or other antibiotics?
Yes ☐ No ☐ Sedatives, Barbiturates?
Yes ☐ No ☐ Aspirin or Ibuprofen?
Yes ☐ No ☐ Local Anesthesia (Novocain, etc.)?
Yes ☐ No ☐ Latex or Rubber products?
Yes ☐ No ☐ Codeine or other painkillers?

***Signature of Parent/Guardian _____ Date_____**

**Relationship to child_____**

**Medical History Continued** **Student Name: _____ Birth Date _____**

**Other allergies or reactions? (include allergies to foods, bees, insects, animals, etc.) Please list:**

_____

_____

_____

**Please list any concerns you have regarding your child' s physical or mental health**:

_____

_____

_____

_____

**DENTAL:**

Name of Dentist: _____ Child's Last dental visit: _____

Do you have any concerns about your child's teeth? ☐ NO ☐ YES Please specify: _____

_____

**FAMILY HEALTH HISTORY:**

Please check below if any of your child's **BLOOD RELATIVES** (i.e. parents, brothers/sisters, aunts, uncles, grandparents) have had any of the following illnesses and note which relative had them:

| YES | NO | ILLNESS | Relative | Explain |
|---|---|---|---|---|
| ☐ | ☐ | Diabetes, Endocrine Disorder (thyroid) | | |
| ☐ | ☐ | Cancer | | |
| ☐ | ☐ | Heart problem, Stroke | | |
| ☐ | ☐ | High Blood Pressure | | |
| ☐ | ☐ | Blood Disorders including Anemia | | |
| ☐ | ☐ | Respiratory Problems including Asthma | | |
| ☐ | ☐ | Mental Illness (ie. Depression) | | |
| ☐ | ☐ | Alcohol/Drug Problems | | |
| ☐ | ☐ | Infections (TB/HIV/AIDS) | | |
| ☐ | ☐ | Death Under the age of 50 | | |
| ☐ | ☐ | OTHER:_____ | | |

I have read the materials regarding School Based Health Center (SBHC) services and also the SBHC Privacy Notice (available at the SBHC) and give permission for my child to receive SBHC services. This medical history is accurate to the best of my knowledge. I understand I should inform the SBHC staff if there are any changes in my child's mental or physical health.

I give permission for the exchange of relevant medical/mental health information amongst SBHC staff, with Windham Board of Education staff, and with outside providers on an "as needed" basis based upon the Privacy Notice unless I object in writing. The goal of this process will be to assist in maintaining health and safety in the schools, and to coordinate my child's care. SBHC charts may be transferred to other SBHC clinics as needed. I understand this authorization remains in effect until my child is no longer a student in a Windham Public School's program.

_____ _____

**Signature** **Date**

_____

**Relationship**