STAMFORD SCHOOL BASED HEALTH CENTERS PERMISSION FORM

Please complete all information requested

Student's Name: ____ Sex: Female: ___Male: __ Birth date ___________
Last First Middle

Address: ____ City: _________________ Zip Code: __________________

Who lives with student? Mother__ Father __Siblings (#)____ other (explain)__________**Total Number of people at home**_______

Female Head of Household: Yes ______ No ______ **Household Income** ____

Race of Student: (Please check at least one)

American Indian or Alaskan Native ____

Asian ____ Black/ African Descent____

Native Hawaiian or Pacific Islander ____White____

Two or More_____________________________

Ethnicity of Student: (Please check at least one)

Hispanic or Latino _____

Not Hispanic or Latino _____

Home Phone: ___________________ Student's Email: ___________________________Student's cell # ____________________
(Indicate student's preferred method of contact)

School: ____ Grade: ___________ Student's Place of Birth ___________________

Who sent student to Health Center?
Community Resource _________________Friend____ Job P.E____ Medical Provider____ Parent or Guardian____ Self____ School Administrator____ School Counselor_____ School Nurse_____ School Social Worker_____ Sports P.E____ Teacher____

Does your child get free or reduced priced lunch? Yes _____ No _____

Contacts:

Parent or Guardian Name: _______________________Day Phone#: ______________ E-mail______________________________

Emergency Contact (if different from above)

Name: ____ Relationship_______________ Phone#________________________

Insurance Information - Must be Filled Out Completely.

Insurance will be billed. However, you are not responsible for any cost or co-pay not covered by your insurance company.

Do you have Health Insurance? Yes ____ No____ If yes, please provide information below.

Medicaid (HUSKY) # ______________________________ **Social Security Number** __________________________________

Or

PRIMARY INSURANCE INFORMATION:

Policy Holder's Name: ___________________________________ Birth Date: _____________Relationship: ___________________

Policy Holder's Address: ____

Policy Holder's Employer Name & Address: ____

Insurance Carrier Name and Address: ____

Policy #: _______________________________ Group #: _____________________ Effective Date of Coverage: ________________

Please include a copy of your insurance card (front and back) with this form. Or, we can make a copy for you.

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FOR OFFICE USE ONLY

SBHC Chart #: ____ **Date Opened** (first visit):__________________________________

Student Name: ____________________________________ Date of Birth ____________________________

If you circle "Yes" to any of the questions below, please list or explain:

Is your child taking any medications (check one) ____ **No** ____**Yes** ____

Does your child have any allergies to food? (check one) _____ **No** ____**Yes** ____

Does your child have any allergies to drugs? (check one) _____**No** ____**Yes** ____

Does your child have any allergies to environmental factors? (check one) _____**No** ____**Yes** __________________________

Does your child have any allergies to latex? (check one) _____ **No** ____**Yes** ____

Does your child have any other allergies? (check one) _____**No** ____**Yes** ____

Has your child ever been hospitalized / had surgery / been injured? **(check one)** ____ **No** ____**Yes**

Has your child had any of the following?

Yes	No	Yes	No	Yes	No
____	____Alcohol/Drug Problems	____	____Heart Problems / Murmur	____	____Pneumonia
____	____Arthritis	____	____Hepatitis / Liver Disease	____	____Pregnancy
____	____Asthma / Reactive Airway	____	____Hernia/Undescended. Testicle	____	____Prosthetics
____	____Attention Deficit Disorder	____	____High Blood Pressure	____	_____Rheumatic Heart Disease
____	____Blood Disorders (Anemia)	____	____High Cholesterol/Triglycerides	____	____Scoliosis, Knee Injury
____	____Broken Bones	____	____Immune Deficiency Disorders	____	____Seizures
____	____Cancer	____	____Measles	____	____Sickle Cell Trait or Disease
____	____Chicken Pox	____	____Meningitis	____	____Skin Disorders
____	____Concussions	____	____Menstrual Problems	____	____Sleeping Problems
____	____Depression / Anxiety	____	____Mental Health Concerns	____	____Stomach / Bowel Problems
____	____Diabetes	____	____Mononucleosis	____	____Thyroid Problems
____	____Ear Infections	____	____Mumps	____	____Tuberculosis
____	____Headaches / Fainting	____	____Organ Removal / Transplant	____	____Urinary Tract Infections
____	____Hearing Problems			____	____Weight or Eating Problems

Please list any concerns you have regarding your child's health:

Family Health History:

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

ILLNESS	Relative	ILLNESS	Relative
___Alcohol/Drug Problems	______________	___High Blood Pressure	______________
___Blood Disorders including Anemia,	______________	___Infections (TB, HIV, AIDS)	______________
___Cancer	______________	___Liver/Kidney Problems	______________
___Death under the age of 50	______________	___Mental Illness, Emotional Problem	______________
___Diabetes, Endocrine Disorder	______________	___ Respiratory Problems including Asthma	______________
___Eczema	______________	___ Sickle Cell Trait or Disease	______________
___Heart problem, Vascular Disease/Stroke	______________	___ Seizures	______________

Where do you get your child's medical care? (Check all that apply)

____Community Health Center	____Military Clinic	____Urgent Care Clinic
____Emergency Room	____No Regular Source	____Unknown
____Health Department Clinic	____Private Doctor	____Walk In Clinic
____Hospital Clinic	____School Based Health Center	____Other Type: ___________________________

Who is your child's healthcare provider? ______________________________Phone #_______________Don't have one ________

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Who is your child dentist? ____Phone #________________Don't have one _______

Name of specialists treating your child __________________________________Phone # ________________Don't have one _______

Student Name: ____ Date of Birth ________________________

Our Dental Clinic is Located at Westhill High School

Open to all Stamford Public School Students

Do you have Dental Insurance? Yes ____ No____ If yes, please provide a copy of your card if different form health insurance.

DENTAL INSURANCE INFORMATION:

Policy Holder's Name: __________________________________Policy Holder's Birth Date: ____________Relationship: __________

Family Centers Inc., School Based Health Center Services Include:

- Assessment of Skin Problems
- Den For Grieving Kids **
- Dental Assessments (including X-rays), Treatments (Fillings, Extractions, Root Canals, including anesthesia) & Referrals.
- Drug, Alcohol & Tobacco Abuse Counseling & Referral
- Immunizations & TB Screening
- Information, Treatment, Referrals for Sexual concerns and problems.
- Laboratory tests (Strep, TB, Anemia, etc.)
- Management of chronic conditions (allergies, asthma, anemia, etc.)
- Preventive Health Education Programs
- Psychiatric Services
- Reaching Independence Through Employment (RITE)
- Referrals To & Follow Up With Medical Specialists
- Individual & Group Counseling
- Nutritional Guidance
- Treatment of Minor Illnesses and injuries
- Young Parents Program (YPP) **
- **Additional permission required.
- Physical Exams

Please Remember to Sign This Form (sign digitally by clicking on signature line or print and sign in ink)

My signature below indicates that I have read the foregoing regarding the services of the School Based Health Centers (SBHC) and have received the Privacy Notice (attached). I give permission for the above named student to obtain services offered at the SBHC while he/she is in school. I give permission for the exchange of relevant health and safety information between the SBHC and appropriate school staff involved in the overall care of the named student within the confines and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the attached Privacy Notice and The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99). The goal of this process will be to assist in maintaining health and safety in schools and to coordinate my child's care. Furthermore, I give permission to the SBHC to release information regarding treatment and/or services (medical, dental and/or behavioral health services) to the named insurance providers for the purpose of billing. I authorize payments to be made directly to Family Centers Inc. for services provided.

____ ____________________

Parent/Guardian/Student (only if 18 or older) Date

If you have any questions, please feel free to contact Dennis Torres, Director of Healthcare Programs at (203) 977-4848