Fair Haven Community Health Care
School Based Health Center

ENROLLMENT FORM

Please complete all information on this permission form. All questions must be answered. You must sign and date the form in order for your child to receive services from the School Based Health Center. If a student is 18 or older or emancipated, he/she can sign his/her own permission form. If you are enrolling multiple children, you will need to complete a separate form for each child.

Student Name:____ ☐ Male ☐ Female
Last First Middle

Address:______________________________City:__________________Zip:__________

Home Phone:____________________Birth Date:__________Social Security #:__________________

Student Cell Phone:____________________Student Email:______________________________

School:______________________________Grade:__________Student ID:__________________

Parent/Guardian Name:______________________________Preferred Language:__________________

Parent/Guardian Daytime Phone:__________________Parent/Guardian Email:______________________

Emergency Contact (*please give us the names of two adults to notify in an emergency if you are not available*):

Contact Name:____________________Phone:__________________Relationship:__________________

Contact Name:____________________Phone:__________________Relationship:__________________

Racial/Ethnic Background of Student (select all that apply):

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

Ethnicity of Student:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ Unreported/Refused

Where do you get your child's health care?

☐ Community Health Center ☐ No Regular Source ☐ Urgent Care Clinic
☐ Emergency Room ☐ Private Doctor ☐ Unknown
☐ Hospital Clinic ☐ School Based Health Center ☐ Other:____________________

Name of Child's Doctor/Clinic:______________________________Phone:__________________

Address:______________________________Date of last Physical Exam:__________________

Name of Child's Dentist:______________________________Phone:__________________

Address:______________________________Date of last Dental Exam:__________________

Preferred Pharmacy:______________________________Phone:__________________

Type of Insurance (check all that apply and complete information on next page)

☐ Private/Commercial Insurance ☐ Medicaid/HUSKY ☐ No insurance

For office use only

Consent Date:______________ MRN:______________ Date Registered: ______________

FAIR HAVEN COMMUNITY HEALTH CARE
School Based Health Center

ENROLLMENT FORM

STUDENT'S INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Policy Holder's Name:______________________________Relationship to student:______________

Policy Holder's Address:______________________________City:________________Zip:________

Policy Holder's Date of Birth:________________Policy Holder's Social Security Number:______________

Insurance Carrier Name:______________________________Insurance Carrier Phone#:____________

Policy#:________________________Group #:___________________Plan#:______________

Medicaid/HUSKY Information

Child's Medicaid #:________________________________Effective Date:____________________

DENTAL INSURANCE INFORMATION

Policy Holder's Name:______________________________Relationship to student:______________

Policy Holder's Address:______________________________City:________________Zip:________

Policy Holder's Date of Birth:________________Policy Holder's Social Security Number:______________

Insurance Carrier Name:______________________________Insurance Carrier Phone#:____________

Policy#:________________________Group #:___________________Plan#:______________

STUDENT'S MEDICAL HISTORY

Has your child had any of these medical problems: *(use "N/A" if none)*

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.):____________________________
5. Does your child take any medications on an everyday or frequent basis? ☐ Yes ☐ No Explain:__________
6. Is your child allergic to or have they had an adverse reaction to a medication? ☐ Yes ☐ No Explain:__________
7. Other allergies or reactions? (Include allergies to foods, insects, animals, etc.) Please list:________________

   ____

By signing this consent, I understand and acknowledge I have read the materials supplied to me regarding the services of the School Based Health Center and I give permission to the above named student to use the services provided by the School Based Health Center for as long as she/he is enrolled in the Branford Public Schools. I understand that I may revoke this permission at any time by submitting written notice of the withdrawal of my consent. I have received and reviewed the Fair Haven Community Health Clinic, Inc. (FHCHC) Notice of Privacy Practices. I authorize FHCHC to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, in accordance with State and Federal law. I give permission to the FHCHC 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 Fair Haven Community Health Clinic, Inc. 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**

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Relationship to Student