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

1. Chronic problems (asthma, diabetes, ADHD, Mental Health, etc.):_____
2. Does your child take any medications on an everyday or frequent basis? ☐ Yes ☐ No Explain:_____
3. Is your child allergic to or have they had an adverse reaction to a medication? ☐ Yes ☐ No Explain:_____
4. Other allergies or reactions? (Include allergies to food, insects, animals, etc.) Please list: _____

SCHOOL HEALTH CENTER SERVICES AVAILABLE TO STUDENTS:

Ages 3-18:

- School Physical Exams
- Treatment of Asthma, Anemia, Acne, and Other Health Problems
- Nutrition and Weight Counseling
- Referral for Specialty Care
- Immunizations
- Mental Health Individual and Group Counseling
- Diagnosis and Treatment of Minor Illness/Injuries
- Issue-oriented Support Groups
- Substance Abuse Education/Counseling
- Crisis Intervention
- Telehealth

Ages 12-18:

- HIV/AIDS/STD Education, Counseling and Testing
- HIV/STD Prevention (including condom availability)
- Pregnancy Testing
- Reproductive Health
- Contraceptive services

Connecticut and Federal laws allows a minor to receive care and treatment without parental consent for sexually transmitted infection (STI), substance abuse, mental health and reproductive health. A minor can receive a HIV test without parental consent.

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 the student 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 acknowledge that FHCHC's Notice of Privacy Practices are posted on www.fhchc.org. 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**

_____

Relationship to Student