

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 East Haven 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 Care, 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