EAGLES HEALTH CLINIC (SBHC) 2020-21 ENROLLMENT FORM

Signature REQUIRED for your child to be seen at the School-Based Health Center (SBHC) for Services Rendered for Student at School

Student Name_____ **Date of Birth**_____
First Middle Initial Last

Race: White Black/African American Asian Native Hawaiian/Other Pacific Islander **Ethnicity**:
American Indian/Alaskan Native Two or More Races Other_____ Hispanic Non-Hispanic

Gender: _____ **Grade**_____

Street Address_____

Town_____ **State**_____ **Zip**_____

Parent/Guardian #1 (Name/relationship)_____

Address of parent (if different)_____

Primary Phone _____**Secondary#**_____**Other#**_____

Email_____

Preferred method of communication (for non-emergencies) _____

Parent/Guardian #2 (Name/relationship)_____

Primary Phone _____**Secondary#**_____**Other#**_____

Email_____

Doctor/Primary Care Provider_____ **Phone**_____

Preferred Pharmacy_____ **Town**_____ **Phone**_____

I give permission for my child _____ to use the School-Based Health Center. I understand that this consent will remain in effect until the student's graduation or withdrawal from school. **I also understand that I may revoke my consent at any time with written notification.**

*I understand that my signature gives permission for the SBHC staff to access my child's school health record, share health information with my child's Primary Care Provider or Dentist and share information with the School Nurse, School Social Worker/Behavioral/Mental Health Therapist, School Counselor or contracted mental professional, when it is deemed appropriate for treatment purposes.

*I understand that the SBHC services are meant to compliment and not replace those provided by my child's Primary Care Provider and all health related information will be treated in a confidential manner.

*I give permission for the Nurse Practitioner, School Nurse and clinic staff to administer needed medications.

*I give permission for the Nurse Practitioner to conduct a health assessment with my student.

*I understand that to provide health care for a student, the School Nurse and staff of the SBHC may share information about my child's health and health history.

*I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices.

Parent/guardian signature_____ Date_____

Student signature (if over 18) _____ Date_____

Health Insurance Information

Please send or fax (725-0143) a copy of health insurance card if possible.

Consent to Release Information to My Insurance Carrier

I authorize release of medical and related information, reportable communicable disease, and mental health records obtained in the course of diagnosis and treatment to my health insurance company or other third party payer for the purpose of obtaining payment for service rendered. Authorization may be withdrawn at any time by written notification.

_____ _____

Parent/guardian signature **Date**

Health Insurance Information (con't)

Whenever possible, health insurance carriers will be billed. Due to pending legislative changes, the MSAD 75 School-Based Health Center is waiting to determine if co-payments will be billed. Please do not let this be a deterrent to signing up – we can make arrangements to help support any student/family in need.

The student is covered by_____
Name of Insurance Company

Insurance Co. Address_____

Insurance Co. Phone #_____

Policy #: _____**Group #**_____

Insurance Plan Type: HMO PPO POS Blue Choice Comp-Care Federal Other_____

The student is covered by Maine Care _____Yes _____No

Maine Care Recipient I.D. Number _____

Social Security Number (optional) _____

Name of **policy holder**_____ **Date of birth**_____

Address of **policy holder**_____

Place of employment of **policy holder**_____

Relationship to student _____

Student Health Information

Please list below any known medical issues or special health concerns. Please include significant past illnesses, injury or hospitalizations.

_____
_____
_____

Current health problems_____

Current medications & dosages: Medication_____Dose_____
Medication_____ Dose _____
Medication_____ Dose_____

Anaphylaxis reaction_____

Medication allergies_____

Date of last eye exam_____ **Glasses** ___ Yes ___ No **Contacts** ___ Yes ___No

History of hearing problems ___ Yes ___ No **Wear hearing aids** ___ Yes ___No

Date of last Tetanus shot_____

Date of last complete physical exam_____

Date of last Dental appointment_____

Dentist_____ **Phone**_____

Family Health History-Please circle where there is a family history of any of the following health conditions:

Heart attack	Heart disease	High blood pressure	High cholesterol	Allergies
Asthma	Sickle Cell Disease	Mental illness	Seizure disorder	Cancer
Diabetes	Tuberculosis	Alcohol or drug abuse	Immune system disorder	

Return completed paperwork to school with your child or mail it in the envelope provided.

Mt. Ararat School-Based Health Center Phone: 729-2951, ext. 8025 Fax: 725-0143 **Rev May 2020**