Fair Haven Community Health Care
School Based Health Center

ENROLLMENT FORM

Please complete all information on the front and back of 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 #: _____

Cell Phone (student): _____ E-mail Address (student): _____

School: _____ Grade: _____ Student ID:_____

Parent/Guardian Name: _____ Preferred Language: _____

Parent/Guardian Work Phone:_____ Parent/Guardian Cell Phone:_____

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:

☐ 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 medical problems?

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.): _____

Does your child take any medications on an everyday or frequent basis? □Yes □ No Explain:_____

Is your child allergic to or have they had an adverse reaction to a medication? □Yes □ No Explain:_____

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 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 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 School Based Health Center 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