

Client ID: _____

Staff Initials: _____

UCFS School-Based Health Center Enrollment Form



- Norwich Technical High School, 7 Mahan Drive, Norwich, CT
- Norwich Free Academy, 305 Broadway, Norwich, CT
- Montville High School, 800 Old Colchester Road, Oakdale, CT

Norwich Public Schools

Waterford Public Schools

School-Based Health Center Line – 860-822-2803

Please indicate what services you would like your child to receive:

- Yes** **No** **Behavioral Health** – Mental Health Assessments, Substance Abuse Screenings, Counseling (individual, group and family)
- Yes** **No** **Medical** - Physicals, Preventive Care, Immunizations, Treatment of Minor Injuries and Illness, Reproductive Health and Health Education
- Yes** **No** **Dental Health** – Dental Hygiene Cleanings, Preventive Care (specific times of the year by appointment only)

Who Can Receive Services? Only students who are enrolled in school where there is a School Based Health Center can receive services. It is not open to the public.

Why Enroll Your Child? Students receive the care they need on premises during the school day without missing class. Parents do not need to miss work to take their child to appointments. UCFS School Based Health Center collaborates and communicates with your child’s primary care provider.

How Do I Enroll My Child? To enroll your child in school-based services, please complete all attached forms in pen and return to the School’s Main Office. Additional forms can be found at UCFShealthcare.org. By enrolling in a UCFS School Based Health Center your child is able to receive services at any UCFS School Based Health Center located in the school your child is enrolled in.

Cost: Insurance is billed whenever possible in order to sustain the UCFS School Based Health Center. However, students will receive care regardless of the ability to pay. Co-pays will be billed directly to the parent/guardian.

Student Information:

Student Name: _____ Date of Birth: _____ Grade: _____

Address: _____ Town: _____

State: _____ Zip: _____ Social Security Number: _____

Phone (Check Primary Number) Cell: _____ Home: _____ Work: _____

Preferred Pharmacy: _____ Pharmacy Town: _____

Email Address: _____

Do you give consent to UCFS to obtain your health history (circle one): **YES** **NO**
UCFS may leave a message with results on: **Home** **Cell** **None**

Is the student now, or have they ever been a UCFS Patient?
If yes, circle all that apply: **YES** **NO**
 Medical **Dental** **Behavioral Health**

Student’s Primary Care Provider Name: _____ **Phone Number:** _____

Student’s Dental Provider Name: _____ **Phone Number:** _____

Student’s Behavioral Health Provider Name: _____ **Phone Number:** _____

Where else does your child receive services? **Emergency Room** **Walk in/Urgent Care Clinic** **Military Clinic**

Preferred Language: _____
Hispanic/Latino (circle one): **YES** **NO**

- Asian American Indian or Alaskan Native
- Black or African American White Native Hawaiian
- Other Pacific Islander Other Please Specify: _____

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Sexual Orientation: Straight heterosexual Lesbian, gay or homosexual Bisexual
 Something Else Don't Know Choose not to disclose

Gender Identity: Male Female Transgender Male/Female-to Male Transgender Female/Male-to-Female
 Gender Queer Other Choose not to disclose

Associated Parties (Please indicate anyone, other than parents, whom UCFS may speak to regarding the following: Please initial all that apply.)

| Name And Address | DOB | Relationship to client | Phone Number | Emergency Contact | Discuss Appointment Information | If Client is a minor May Bring to Appointments |
|------------------|-----|------------------------|--------------|-------------------|---------------------------------|--|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Responsible Party (Please use if Minor under 18 for Parent, Guardian, DCF, POA)

| | | |
|----------------------|-------------------------|----------|
| Name: | Relationship to Client: | DOB: / / |
| Address: | Primary Phone#: | |
| City/State/Zip code: | Secondary Phone#: | |
| Name: | Relationship to Client: | DOB: / / |
| Address: | Primary Phone#: | |
| City/State/Zip code: | Secondary Phone#: | |

How many people are in your household? _____
 Have you been homeless any day during the last 12 months (circle one)? **YES** **NO**
 When? _____

| | | |
|---|--|--|
| What is your estimated household income per year? | | |
| <input type="checkbox"/> \$0-\$9,999 | <input type="checkbox"/> \$10,000-\$19,999 | <input type="checkbox"/> \$20,000-29,999 |
| <input type="checkbox"/> \$30,000-\$39,000 | <input type="checkbox"/> \$40,000-\$49,000 | <input type="checkbox"/> \$50,000+ |

I/We (Print Name) _____; (Print Name) _____ hereby state that I/we are the legal parent(s) of the child indicated below and I/we have the authority to make decisions on all medical and treatment services. I/we hereby request and give permission to United Community & Family Service, Inc., to treat my/our child who is listed below.

Child's Name (Print name) _____ Child's D.O.B. _____

If an alternative legal Parent/Guardian is not present upon completion of this document, please indicate the individual who also has the authority to make medical and treatment decisions on the child's behalf.

Name of legal Parent/Guardian not present; (Print name) _____

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Insurance Information:

Primary Medical/Behavioral Health Insurance Plan: _____

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Policy Holder DOB: _____ Policy Holder SS#: _____ Employer: _____

Group Number: _____ Policy Number: _____

Secondary Medical/Behavioral Health Insurance Plan: _____

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Policy Holder DOB: _____ Policy Holder SS#: _____ Employer: _____

Group Number: _____ Policy Number: _____

Dental Insurance Plan: _____

Policy Holder First Name: _____ Last Name: _____ Middle Initial: _____

Policy Holder DOB: _____ Policy Holder SS#: _____ Employer: _____

Group Number: _____ Policy Number: _____

Would you like someone to contact you about applying to (circle one): **Insurance (Husky)** **SNAP (Food Stamps)**

Payment Information:

| | | | |
|---|--|-------------------------------|--|
| Who is responsible for payment of services provided | | <input type="checkbox"/> Self | <input type="checkbox"/> Other (Please complete below) |
| Relationship: | | | |
| Name: | | Birthdate: | |
| Address: | | Social Security #: | |
| City/State/Zip code: | | Employer Name: | |
| Home Phone #: | | Cell Phone #: | |

By signing below, I authorize UCFS to communicate with the Associated Parties listed above regarding routine appointment information and/or, if client is a minor, I authorize such person(s) to bring my child in for routine appointments

I understand that it is my responsibility to update UCFS with changes to the Associate Parties listed above. What I have provided above will remain active and in effect until such time new information is provided to UCFS.

By checking this box, I am acknowledging that I have been offered/received the UCFS Patient Handbook

Printed Name: _____

Date: _____

Signature of client patient or legal guardian: _____

Client ID: _____

Staff Initials: _____

**UCFS School-Based Health Center
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Student Health History

Student Name: _____ Date of Birth: _____

Does your child have any of the following conditions?

| | | | | | | | | | |
|---------------------|--------------------------|-----|--------------------------|----|---|--------------------------|-----|--------------------------|----|
| ADD/ADHD | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Heart Disease/Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Anemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Hypertension | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Asthma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Immune Disorder | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Birth Defects | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Learning Difficulties/Developmental Delays | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Bipolar | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Mental Illness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Cancer | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Overweight | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Diabetes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Seizures | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dental Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Sleeping Problems – At what age did your child sleep through the night? _____ | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Depression | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Substance Abuse (alcohol or drugs) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eczema | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Tobacco Use | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| HIV/AIDS | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Thyroid Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Head Injury | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Tuberculosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Hearing Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Weight Loss | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| High Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | Other Conditions/Concerns: | | | | |

Has your child been in the hospital overnight? Yes No When: _____ Why: _____

Has your child had surgery? Yes No When: _____ Why: _____

Has your child been in a serious accident? Yes No When: _____ Why: _____

Does your child take any medicines? Yes No Name of Medicine: _____

Does your child take any vitamins or supplements? Yes No Please list: _____

Is your child allergic to any medicine? Yes No Name of medicine: _____

Is your child allergic to food or other things? Yes No Name of food/other: _____

Has your child had chicken pox? Yes No At what age? _____

Is your child receiving any counseling at this time? Yes No Where? _____

Has your child been in counseling in the past? Yes No Where? _____

If female, is the student:

Pregnant or possibly pregnant? Yes No

Having Menstrual Problems? Yes No

For dental services, does the student:

Have special mobility needs? Yes No Have any needs the hygienist should know before treating the student? Yes No

Have experience seeing a dentist? Yes No Have gums that bleed while brushing or flossing? Yes No

Require pre-medication before dental treatment? Yes No Have teeth causing him/her pain? Yes No

FAMILY HISTORY: Does anyone in the child's family have the following conditions? (Mother, Father, Sibling, Grandparent)

| | Family Member | Family Member |
|-----------------|--|--|
| ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immune Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Defects | <input type="checkbox"/> Yes <input type="checkbox"/> No | Learning Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bipolar | <input type="checkbox"/> Yes <input type="checkbox"/> No | Overweight <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |

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Consent for Services:

Student Name: _____ Date of Birth: _____

Consent: By signing below, I understand and acknowledge I have read and understand this consent.

I give permission for my child to receive the following services at the UCFS School Based Health Center. I certify that the health information provided is accurate to the best of knowledge. I understand that providing incorrect information may be dangerous to the student's/patient's health. I will contact school based staff if my child's health history changes.

Medical Services

- Teenagers may avoid getting needed care for certain problems unless they know that they can be treated confidentially and parents most often would prefer that their children have a place to turn when they need medical care. Adolescents, while encouraged to communicate with their parents, can receive confidential services for Sexually Transmitted Disease Testing and Treatment, Pregnancy Testing, Family Planning Counseling and Referral and Substance Abuse Counseling and Referral. I understand my adolescent may choose to receive confidential services. I understand that information regarding the above conditions will be shared if the adolescent agrees or when there is a serious health risk that requires reporting by State or Federal law.

Smiles on the Move Mobile Dental

Check here if you would like to be contacted by Smiles on the Move.

Release of Information and Payment Authorization

- I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to UCFS for services provided.

Authorization for Exchange of Health and Education Information:

- I hereby authorize UCFS to exchange health and education records with my child's school district for the purpose of providing treatment to my child.

Consent and Acknowledgement of Privacy Practices:

- I consent to the use of disclosure of my protected health information by UCFS to any person or organization or the purposes of carrying out treatment, obtaining payment, or conducting certain health care operations. Protected health information used or disclosed by UCFS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how UCFS will use and disclose my information can be founded in UCFS' Notice of Privacy Practices. I understand that this consent is effective for as long as UCFS maintains my protected health information.
- I acknowledge that I have received the UCFS Patient Rights and Responsibility Policy.
- I understand my child will continue to be enrolled in the UCFS School Based Health Center, as long as, the child is enrolled in a school with a UCFS School Based Health Center.
- Annually demographic information will be updated and at any time I have the right to opt out of the School Based Health Center at UCFS by emailing sbhc@ucfs.org.

Printed Name

Relationship

**Signature of client, parent, legal guardian
Personal representative**

Date

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Consent for Flu Immunization Administration

Patient Name: _____ DOB: _____
School: _____

By signing below, I authorize UCFS to administer this season's flu vaccine and have read, or had explained to me, the information sheet about the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request the influenza vaccine be given to me (or my child).

Signature of parent or guardian _____

Yes ___ No ___ Would like to be present when the vaccine is given to my child.

Yes ___ No ___ Are you allergic to eggs?

Yes ___ No ___ Have you ever had a serious reaction to a flu shot?

Yes ___ No ___ Have you ever had Guillain-Barre Syndrome?

Injection site _____ Lot # _____ Expiration date _____

Date admin _____ Administered by: _____