SBHC
School Based Health Center

Enrollment Form
(203) 696-3260

OPTIMUS HEALTH CARE

Patient Information

First Name _____ Last Name _____

Date of Birth _____ Social Security _____

Primary Language _____ Grade _____

Address _____ City, State _____

Zip Code _____ Name of School _____

Gender Identity ☐ Male ☐ Female ☐ Transgender Male (Female to Male) Transgender Female ☐ Male to Female)
☐ Other ☐ Decline to Answer

Ethnicity ☐ Hispanic ☐ Non-Hispanic Decline to ☐ nswer

Race (Check off all that apply)

☐ Black/African American ☐ Caucasian (White) ☐ American Indian/Alaska ☐ Asian
☐ Native American Pacific Islander ☐ Native Hawaiian ☐ Multiple Races ☐ Decline to Answer

Parent/Guardian/Emergency Contact Information

First Name _____ Last Name _____

Date of Birth _____ Social Security Number _____

Home Phone _____ Cell Phone _____

Parent/Guardian Email Addresss _____ Relationship _____

Emergency Contact Name

Emergency Contact Name _____ Relationship _____

Home Phone _____ Cell Phone _____

Pharmacy _____ Pharmacy Address _____

Insurance Information: Please provide the following medical and dental insurance information noted on the back of your insurance/medicaid card.

Primary Insurance _____ Policy Holder Name _____

Policy Number _____ Policy Holder Date of Birth _____

Primacy Insurance Contact Number _____

Does the patient have Dental Insurance? _____ Yes/No _____

Dental Insurance _____ Policy Holder Name _____

Policy Number _____ Policy Holder Date of Birth _____

Dental Insurance Contact Number

Medical History/Allergies

Does the patient have any medical conditions?	☐ Yes	☐ No
Does the patient take any medication? (Including Inhalers)	☐ Yes	☐ No
Does the patient have any allergies to food, medications, or local anesthetics?	☐ Yes	☐ No
Does the patient carry an EPI-PEN at school in case of an allergic reaction?	☐ Yes	☐ No
Has the patient had any serious injuries?	☐ Yes	☐ No
Does the patient have a birth or heart defect?	☐ Yes	☐ No
Does the patient have history of heart problems or surgery?	☐ Yes	☐ No
Has the patient ever been hospitalized overnight?	☐ Yes	☐ No
Has the patient had any surgery in the past?	☐ Yes	☐ No
Has the patient had any shunts placed or have an indwelling catheter?	☐ Yes	☐ No
Does the patient smoke or chew tobacco?	☐ Yes	☐ No

If answered yes to any of the above, please comment below

Please list any concerns you have regarding your child's Physical or Mental Health

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Dental History

Any pain or problems with teeth?	☐ Yes	☐ No
Any bleeding when brushing or flossing	☐ Yes	☐ No
Had a dental cleaning within the last 6 months?	☐ Yes	☐ No
Is premedication with antibiotics needed prior to dental procedures?	☐ Yes	☐ No

If answered yes to any of the above please comment

Family History

		Illness	Relative	Explain
☐ Yes	☐	Diabetes, Endocrine Disorder (Thyroid)		
☐ Yes	☐	Cancer		
☐ Yes	☐	Heart Problem, Stroke		
☐ Yes	☐	High Blood Pressure		
☐ Yes	☐	Blood Disorder including Anemia		
☐ Yes	☐	Clotting Disorders		
☐ Yes	☐	Respiratory Problems including Asthma		
☐ Yes	☐	Mental Illness (i.e. Depression)		
☐ Yes	☐	Alcohol/Drug Problems		
☐ Yes	☐	Infections (TB/HIV/AIDS)		
☐ Yes	☐	Death Under the age of 50		
☐ Yes	☐	Other		

Primary Care Provider

Primary Care Provider Name _____ Addresss _____

Phone _____ Fax _____

Parent/Guardian Consent & Signature

I give my child permission to obtain ON-SITE MEDICAL SERVICES.	☐ Yes	☐ No
I give my child permission to obtain ON-SITE/MOBILE DENTAL SERVICES	☐ Yes	☐ No
I give my child permission to obtain ON-SITE BEHAVIORAL HEALTH SERVICES	☐ Yes	☐ No

I, the parent/guardian of the student, give consent for my child to receive the services checked above at the school-based health center. I understand that this consent will be valid for two years, or until I provide the school-based health center staff written notice of my revocation. All healthcare information is confidential under applicable law.

I understand that my consent permits the school-based health center staff to communicate my child's health information on an as needed basis with the school nurse and your child's regular doctor (if applicable) with the understanding that this information will continue to be treated as confidential under applicable law. No student will be denied access to health care services due to the inability to pay. When available, insurance or Medicaid will be billed. I consent to the health center releasing information regarding treatment to third party payors for billing purposes.

I understand that confidentiality between my child and the health center staff will be maintained for certain services in accordance with applicable law. By law, some information requires your child's written consent prior to disclosure to anyone, including parents/guardians. The health center staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes, a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the health center clinician/staff and the alternative contact.

SIGNATURE	DATE
Print Name	Relationship to Patient