SCHOOL-BASED HEALTH CENTER PERMISSION FORM

Complete/sign this form in order for your child to receive services at the School-Based Health Center

STUDENT/PATIENT INFORMATION:

Student's Name _____ Female ☐ Male ☐
Last First M.I.

Home Address _____ City _____ Zip Code _____

Date of Birth ____/____/_____ Grade _____

CHILD'S RACE/ETHNICITY: *check all that apply*

Black or African American ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐
Native Hawaiian/Pacific Islander ☐ Other ☐ _____ Unknown ☐ _____

Hispanic/Latino Yes ☐ No ☐

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name(s) _____ Relationship to child_____

Address _____ Email _____

Home Phone _____ Work _____ Cell _____

Parents: Married ☐ Divorced ☐ Never Married/Single ☐ Separated ☐ Mother/Father Deceased ☐

EMERGENCY CONTACT:

Name _____ Phone _____ Relationship _____

HOUSEHOLD MEMBERS: *check all that apply*

Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Foster Parent ☐ Brothers ☐ Sisters ☐
Other Family Members ☐ Non-related Adults ☐ Non-related Children ☐

Number of people living in household_____ Female-headed household? Yes ☐ No ☐

HOUSEHOLD INCOME:

Please note the income for your household. Include income from all household members 16+ who are not in school.

Approximate family income per year _____ (*Only used for program funding purposes)

Does child qualify for the free/ reduced lunch program? Yes ☐ No ☐

HEALTH CARE PROVIDER:

Primary Care Doctor _____ Address _____ Phone _____
Dentist _____ Address _____ Phone _____
Pharmacy _____ Address _____ Phone _____

INSURANCE: (***Provide a copy of your current insurance card**)

HUSKY A ☐ HUSKY B ☐ TITLE 19 STATE MEDICAID ☐ PRIVATE/COMMERICIAL ☐ UNINSURED ☐

MEDICAID/HUSKY A or B	**PRVIATE/COMMERCIAL**
Child's ID # _____ Child's name on card _____ If your child does not have health insurance call 1-877-CT-HUSKY	Insurance company name: _____ Plan name: _____ ID # _____ Group # _____ Policy holder's name_____ DOB _____ Policy holder's address _____ Policy holder's employer_____

STUDENT'S MEDICAL AND BEHAVIORAL HEALTH HISTORY:

Child's height in inches: _____ Child's weight: _____

Is the student currently taking any medication? (list medication and dose): _____

Y ☐ N ☐ Hospitalizations/surgeries (list event and date): _____

Y ☐ N ☐ Does your child have an asthma action plan? (if yes, please provide a copy) _____

Please check Yes or No and explain in the space provided

Medical History	**No**	**Yes**	**If yes, please explain**
Allergies (food, medication, environmental, etc.)			
Vision (contacts/glasses)			
Hearing			
Fainting/seizures			
Heart problems			
Blood pressure/cholesterol			
Asthma			
Blood disorders (anemia, sickle cell, etc.)			
Diabetes/thyroid/endocrine			
Injuries (concussion, broken bones, etc.)			
Headaches/migraines			
Stomach problems			
Weight/eating issues			
Skin problems			
Ear infections			
Dental problems			
Special need/disability			
Other			
Mental Health History	**No**	**Yes**	**If yes, please explain**
Anxiety/depression/mood disorders			
Loss/divorce issues			
ADHD/ADD/learning disorder			
Autism/Aspergers			
Eating disorder/weight problem			
Cutting/self-harm			
Smoking/alcohol/drugs			
Academic failure			
Sleep problems			
Behavior problems			
Other			

Y ☐ N ☐ Is your child currently in counseling? Therapist/Provider: _____

Y ☐ N ☐ History of counseling: Dates: _____ Therapist/Provider: _____

Please check box if your family has a history of the following:

☐ ADHD/ADD ☐ Alcohol/Drug Use ☐ Anxiety/Depression ☐ Other Mental Health Problems

Read each statement below and sign to acknowledge: (This permission can be rescinded in writing at any time)

☐I give permission for my child to obtain all services offered at the School-Based Health Center at Wooster Middle School. I understand that services provided to my child are **confidential** except in life-threatening emergency situations and in accordance with the law. I give permission to exchange information to appropriate persons when deemed necessary to ensure the health and safety of my child and for the purpose of providing healthcare, diagnosis, treatment and counseling services (confidential health records will not be shared without permission in accordance with the law).

☐I acknowledge that I have received a copy of the "Privacy Notice" for the Health Center and understand that I may contact the Health Center if I have questions about the content of this notice.

☐ I authorize Wooster School-Based Health Center (Health Haven) to bill my insurance carrier for any covered services. I understand that I **WILL NOT** be billed by for services not covered by my insurance carrier. I give permission for the release of information to my insurance company regarding treatment of services for the purpose of billing. I authorize insurance payments to be made directly to Wooster School-Based Health Center for services provided.

_____ _____

Parent/Guardian Signature Date