2009-2010
Student Health Center Enrollment Form
Grades 6-12

Parents - Please complete and sign this enrollment form that allows your child to use the Student Health Center for one year. For special situations, students are allowed to complete and sign the enrollment form themselves. **(See consent section on back).**

Student Name ____ Date of birth _______________ Gender: ____male ____female

School _________________________________ Grade level _____________________ Student ID # _________________________

Race: ____White ____Black ____Asian ____Native American/Alaskan native ____Native Hawaiian/Pacific Islander

____Other race (Specify) ________________________ ____Two or more races (Specify) ______________________________

Are you Latino or Hispanic? _____ yes _____no What country were you born in? ________________________________

What is the primary language spoken in your home? _________________________

Address: ____ Zip ___________ Home Phone: _______________

Parent work phone:_____________________ Parent cell phone:____________________ Student cell phone:_________________

Parent(s) or legal guardian(s)____________________________ Address (if different than above) ______________________________

Student Health Information

Please complete the following important information that will help us to know about your child's health needs:

Doctor/Health Care Provider: ______________________________ Check here if your child does not have a health care provider: ____

My child had his/her last physical exam within the last two years. _____ yes _____ no _____ don't know

My child will need immunizations this year. _____ yes _____ no _____ don't know

Significant past illnesses, injuries or hospitalizations ____

____

Allergies: ____ Asthma: ____yes ____ no Cardiac disorder: ____ yes ____ no

Other physical, dental or mental health problems: ____

Current medications:____

Family Health History – Please check off where there is a family history of any of the following health conditions:

_____Allergies
_____Asthma
_____Alcohol or drug abuse
_____Cancer
_____ Diabetes
_____ Heart disease
_____ High blood pressure
_____ High cholesterol
_____Immune disorder
_____Mental illness
_____Seizure disorder
_____Tuberculosis

Does your child receive yearly dental care? _____ yes, at a private dentist
_____ yes, at Community Dental
_____ no, we need a dentist/dental care

If your child does not have a dentist or goes to Community Dental, would you like your child to receive preventive dental services at school? _____ yes _____ no

Does your child have dental pain (toothache)? _____ yes _____ no

(See back)

Health Insurance Information (VERY IMPORTANT – PLEASE COMPLETE)

Do you have Medicaid/MaineCare coverage? _____ yes _____ no   Do you have private insurance coverage? _____ yes _____ no

If employed, name of insured parent's employer ________________________ Check here if you have no health insurance ______

If you have MaineCare or private insurance, please provide us with a photocopy of your insurance card or fill-in the information on the blank sample card shown below. You may also have your child bring the card to us at the health center and we will make a copy.

Title of card ____________________________

Insured person's name ____________________

Policy ID or Medicaid # ___________________

Group # _______________________________

Physician ______________________________

Consent to use the Student Health Center

I give permission for my child, ____, to use the Student Health Center for one year which may include receiving physical, dental or mental health services.

*** I understand that my signature indicates that I have received and read the Student Health Center <u>Enrollment Information.</u>**

*** I understand that my signature indicates that I have received a copy of the <u>Privacy Notice</u>.**

*** I understand that my signature also gives permission for Student Health Center staff to access my child's school health record and share pertinent health information between the Student Health Center staff and school nurse or school social worker when it is deemed appropriate for treatment purposes.**

*** I understand that my signature allows for pertinent physical, dental and mental health information to be shared between the Student Health Center staff and my child's doctor or dentist as well as personnel from Community Counseling Center when and if my child is accessing those services in order to facilitate treatment services.**

*** I understand that I may revoke this authorization at any time by written notice sent to the address below. Such revocation shall not affect any uses or disclosures permitted by your authorization while it was in effect.**

Parent/guardian signature ____ Date_____________________

Print Name:____**Relationship**_________________________________

Students may sign for themselves in the following special situations:

1. Students who are 18 years old or older
2. Students who are married
3. Students who are emancipated (requires legal court action)
4. Students who are living independently (living separately from parent or guardian for at least 60 days and independent of parental support).

I am a student who fits into one or more of the four special situations listed above and can sign consent for myself. (Please circle the number(s) that fit your situation) - 1 2 3 4

Student Signature ____ Date ____________________________

Please return this form to the Student Health Center or school nurse; or mail/fax to:
City of Portland, Health & Human Services Department, Public Health Division
166 Brackett Street
Portland, ME 04102
Fax 874-8477