2006-2007
Student Health Center
Enrollment Form
Grades K-8

Parents - Please complete and sign this enrollment form to give consent for your child to use the Student Health Center for one year. **(See consent section on back).**

Student name ____ Date of birth________________ Gender: _____male _____female

School____ Student ID# _________________ Grade level ________________________

Race: ____White ____Black ____Asian ____Latino/Hispanic ____American Indian/Alaskan native ____Pacific Islander
____Other race (Specify) ________________________ _____Two or more races (Specify) __________________________________

What is your country of origin? ____________________ What is the primary language spoken in your home? _________________

Social Security # ___________________ Address:_________________________________ Home phone:____________________

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

Parent(s) or legal guardian(s)_________________________________ Address (if different than above) _______________________

Doctor or Health Care Provider ______________________________ My child does not have a doctor or health care provider:_____

Student Health Information

Please list below any known medical issues or special health concerns that will help us manage your child's health needs.

Significant past illnesses, injury or hospitalizations ____

____

Allergies:_______________________________________ Asthma: _____yes _____no Cardiac disorder: _____yes _____no

Other physical, dental or mental health problems:____

Current medications:____

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

________ Heart attack
________ Heart disease
________ High blood pressure
________ High cholesterol
________ Allergies
________ Asthma
________ Immune system disorder
________ Diabetes
________ Cancer
________ Seizure disorder
________ Sickle cell disease
________ Tuberculosis
________ Alcohol or drug abuse
________ Mental illness

Please check the following:

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

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

Dental Health Information

Does your child have a dentist? ____yes ____no If yes, dentist's name ____

If no, would you like help finding a dentist? ____yes ____no

When was the last time your child went to the dentist? ____within the last year ____over one year ago ____never

Important insurance information below – please complete

Health Insurance Information

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

If employed, name of insured parent's employer ____ Phone ___________________

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 ____________________________

Check here if you have no health insurance _____.

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 physical, dental or mental health services.

*** I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices.**
*** I understand that my signature also gives permission for the Student Health Center staff to access my child's school health record, share health information with my child's doctor or dentist and share information with the school nurse or school social worker when it is deemed appropriate for treatment purposes.**

Parent/guardian 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
389 Congress Street, Rm #307
Portland, ME 04101
Fax 874-8913