GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

2019-2020 School-Based Health Center Enrollment Form

Please complete and return to school

Child's name _____ Date of Birth _____ /_____/_____ Gender M F T
(Same as on MaineCare card, if applicable)

Address _____ Zip Code _____ Homeless ☐

Parent daytime phone _____Msg. OK yes/no Other phone _____Msg. OK yes/no

Student's cell (for appointment reminders) _____Msg. OK yes/no School_____ Grade_____

MaineCare ID Number (ends in A) _____

Private Insurance Name _____Policy ID# _____

Group #_____ Claim address_____

Policy Holder's Name_____ Policy Holder's Date of Birth_____

Uninsured _____

If you are uninsured, one of our financial assistance counselors will contact you to discuss insurance and our sliding fee scale options.

Health History

Primary Doctor/Health Care Provider: _____

My child had a physical exam within the last two years. ___ yes ___ no ___ don't know

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

Does your child have Asthma? yes/no Written Asthma Plan at school? yes/no

Does your child have Diabetes? Yes/no Written Diabetes Plan at school? Yes/no

Other physical, dental or mental health problems: _____

_____

Allergies:_____

Family Health History – Please check family history for any of the following health conditions:

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

Significant past illnesses, injuries or hospitalizations: _____

Current Medications: _____

Child's Race: _____ White _____ Black, African, African American _____ Other Pacific Islander _____ Asian
_____South/Central/North American Indian, Alaska Native _____ Hawaiian _____ Multiracial

Total Annual Household Income: _____ Total number of family members living in the household: _____

Consent to Use Greater Portland Health School Based Health Center & Authorization for Release of Information

I give permission for my child, _____, to use Greater Portland Health's School-Based Health Center which may include receiving medical, dental or mental health services. I also authorize the SBHC to complete a Rapid Assessment for Adolescent Preventive Services© (RAAPS) risk assessment of my child as it may, in its sole discretion, deem necessary or appropriate (for more information, go to raaps.org).

- I understand that my signature indicates that I have received and read Greater Portland Health's School-Based Health Center Parent Letter.
- I understand that my signature indicates that I have received and read Greater Portland Health's School Based Health Center Privacy Notice.
- I hereby authorize Greater Portland Health's School-Based Health Center staff to access my child's school health record and authorize Greater Portland Health's School-Based Health Center staff and the school nurse or school social worker to share pertinent health information and records when it is deemed appropriate for treatment purposes.
- I hereby authorize my child's primary care provider, dentist, and mental health professional to share health information and records with the School-Based Health Center to support care for my child, and I give permission to Greater Portland Health's School-Based Health Center to share health information and records with my child's primary care provider, dentist, and mental health professional as appropriate to facilitate treatment services and the continuity and coordination of care..
- Authorization: This authorization is valid for the duration of time that the student is enrolled with the Portland School System or until they transfer to another school (i.e. from middle school to high school). I acknowledge that when my student transfers from middle school to high school, I must re-enroll them in the health center if I would like them to continue receiving services at Greater Portland Health's School-Based Health Center. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, if received by the school district, may not be protected by the HIPAA Act, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I have read this form completely and agree to enroll my student in the health center at this time.

Parent/Guardian Signature: _____Date:_____

Print Name: _____Relationship_____