

## 2021-2022 School-Based Health Center Enrollment Form

**\*\*Please complete and return to school\*\***

School Name: _____	School Grade Level: _____
Student Name: _____ (Same as on MaineCare card, if applicable)	Date of Birth ____/____/____      Gender M F T Intersex
Address _____	Zip Code _____      Homeless <input type="checkbox"/>
Parent Phone: _____ Msg. OK yes/no      Email address for Telehealth _____	

Insurance Name _____	Policy ID# _____
Group # _____	Claim address _____
Guarantor/Parent Name: _____	Phone # _____
MaineCare ID Number ( Ends in A) _____	

**Are You Uninsured: Yes / No**

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

**Health Information:**

Primary Doctor/Health Care Provider: \_\_\_\_\_

My child had a physical exam within the last two years.     YES     NO     Unsure

My child will need immunizations this year.     YES     NO     Unsure

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: \_\_\_\_\_

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

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Immune disorder	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Alcohol or drug abuse	<input type="checkbox"/> High blood pressure

Student Race: <input type="checkbox"/> White <input type="checkbox"/> Black, African, African American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian
<input type="checkbox"/> South/Central/North American Indian, Alaska Native <input type="checkbox"/> Hawaiian <input type="checkbox"/> Multiracial

Total Annual Household Income: _____	Total number of family members living in the household: _____
Head of Household Name: _____	Relationship to Student: _____

By signing this form, I am acknowledging and understand that:

- I have received and read Greater Portland Health’s (“GPH”) School-Based Health Center Parent Letter, which explains what the GPH School Based Health Center is and what services and benefits it might provide for my child.
- The GPH’s School Based Health Center is a separate entity from the school and from the school nurse’s office. The GPH Health Center provides primary care assessments and a range of health care treatment in a school-based location while engaging in communications with other health care providers who may also be involved in the care of my child.
- This Consent is valid for the duration of time that the student is enrolled with the Portland School System, Westbrook School system, or South Portland School System or until they transfer to another school (i.e. from middle school to high school). When my student transfers from middle school to high school, I must re-enroll them in the GPH School Based Health Center if I would like them to continue receiving services at GPH’s School-Based Health Center.
- I am required to review and sign the Authorization Form for the Use and Disclosure of Health Care Information in connection with my child’s enrollment in the GPH School Based Health Center.

I have read this form completely and agree to enroll my student in the GPH School-Based Health Center at this time.

**Parent/Guardian Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_