



Connecticut Institute for Communities, Inc.

School Based Health Centers Permission Form

All information on the front and back of this permission form must be completed, dated and signed before your child can receive services from the School Based Health Centers. If a student is 18 or older, he/she may sign his or her own permission form. *Race /* Ethnicity information is required by the State and will be used for statistical purposes only.

Student Name (Last, First, M.I.)	Date of Birth (month/day/year)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	Grade/Cluster
Street Address (Street, Town, State, ZIP code)		Home Number	
Please check one: <input type="checkbox"/> Broadview MS <input type="checkbox"/> Rogers Park MS <input type="checkbox"/> Danbury HS <input type="checkbox"/> Henry Abbott Tech HS			Student's Cell Phone Number

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)		Parent/Guardian E-Mail address
Home Phone Number	Cell Phone Number	Work Phone Number

Parent/Guardian Name	Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)		Parent/Guardian E-Mail address
Home Phone Number	Cell Phone Number	Work Phone Number

Emergency Contact Name	Relationship to Student
Home Phone Number	Cell Phone Number
	Work Phone Number

*Race: (Please check one) <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Refuse to Report	In what country was the student born?
*Ethnicity: Hispanic/Latino? <input type="checkbox"/> YES or <input type="checkbox"/> NO What language(s) does the student speak? (check all that apply) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other: _____	Translator needed: <input type="checkbox"/> YES or <input type="checkbox"/> NO
Is the student on the free or reduced lunch program? <input type="checkbox"/> YES or <input type="checkbox"/> NO	Estimated Family Income \$ _____ # of family members _____

Medical Care	Dental Care <i>**Please provide a copy of dental insurance card</i>
Name of Doctor or Medical Clinic: If No doctor, write "NONE" below	Name of Dentist: If No Dentist, write "NONE" below
Doctor's Address (Street, Town, State, ZIP)	Dentist's Address (Street, Town, State, ZIP)
Doctor's Phone Number: _____	Date of last physical exam: _____
	Dentist's Phone Number: _____
	Date of last dental exam: _____

Pharmacy Name: _____ Address: _____ Phone #: _____

<p>Does the student have MEDICAID/Husky Insurance: YES or NO Medicaid Pending: YES or NO **Please provide a copy of the insurance card</p> <p>If your child does not have health insurance Please call 1-877-CT-HUSKY</p> <p>Medicaid #: _____</p> <p>Child's name on Card: _____</p> <p>*If NO insurance, contact SBHC for enrollment assistance*</p>	<p>Does the student have Private/Commercial Insurance: YES or NO **Please provide a copy of the insurance card</p> <p>Name of Insurance Company: _____</p> <p>Policy Holders Name: _____</p> <p>Policy Holders Date of Birth: _____</p> <p>Policy Holders Address: _____</p> <p>Policy Holders Employer: _____</p> <p>Relationship to student: _____</p> <p>Insurance Number for the student: _____</p> <p>Group number: _____</p>
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Broadview Middle School (203) 731-8274 Fax: (203) 731-8275
Danbury High School (203) 790-2886 Fax: (203) 797-4793
Ellsworth Avenue School (203) 456-1408 Fax: 866-800-7321

Rogers Park Middle School (203) 778-7479 Fax: (203) 778-7481
Henry Abbot Tech. HS (203) 797-4460 Ext. 4936 Fax: (203)-731-2914

****PLEASE ANSWER ALL QUESTIONS AND SIGN AND DATE PAGE 2****

SBHC Medical History Form (page 2)

Student's Name: _____

Date of Birth: _____

Is the student currently taking any medications? Yes No If YES, please list below including dosages and how often.
(Include asthma inhalers and EpiPens)

Medical History: **Please check all boxes that apply and explain on the lines below:*

- | | | |
|---|--|--|
| <input type="checkbox"/> Hospitalization or Surgery | <input type="checkbox"/> Fainting or Blacking-Out | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Allergies (food, medication, bees, etc.) | <input type="checkbox"/> Running / Exercise Problems | <input type="checkbox"/> History of Seizures |
| <input type="checkbox"/> Seasonal / Environmental Allergies | <input type="checkbox"/> Asthma / Breathing Issues | <input type="checkbox"/> Headaches / Migraines |
| <input type="checkbox"/> Broken bones, Dislocations | <input type="checkbox"/> Blood Disorders /Anemia / Sickle Cell | <input type="checkbox"/> Diabetes/Thyroid/Endocrine |
| <input type="checkbox"/> Muscle or Joint Injuries | <input type="checkbox"/> Vision Problems (Contacts / Glasses) | <input type="checkbox"/> Weight or Eating Issues |
| <input type="checkbox"/> Neck or Back Injuries | <input type="checkbox"/> "Mono" | <input type="checkbox"/> Females: Menstrual problems |
| <input type="checkbox"/> Heart Defects / Murmurs | <input type="checkbox"/> TB or Positive Skin Test | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> High Blood Pressure / Cholesterol | <input type="checkbox"/> Skin Problems (Eczema, Psoriasis) | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Chest Pain during or after exercise | <input type="checkbox"/> Dental Problems (Pain / Bleeding) | <input type="checkbox"/> Any other medical problems |

Is the student under the care of any medical specialist? Yes No

Has student seen a dentist within the last year? Yes No Has student seen same dentist for more than one year? Yes No

Mental Health History: **Please check all boxes that apply and explain on the lines below:*

- | | |
|--|---|
| <input type="checkbox"/> Mood Disorder / Depression | <input type="checkbox"/> Learning Disorder / ADD / ADHD / Autism Spectrum |
| <input type="checkbox"/> Anxiety / Panic / OCD | <input type="checkbox"/> Loss / Divorce / Deportation of family members |
| <input type="checkbox"/> Anger / Other behavioral issues | <input type="checkbox"/> Substance use / Vaping |
| <input type="checkbox"/> Academic Concerns | <input type="checkbox"/> Eating / Significant Weight Loss or Gain |
| <input type="checkbox"/> Cutting / Self-harm | <input type="checkbox"/> Other unlisted concerns |

Family History: **Please check all boxes that apply and explain on the lines below:*

- | | |
|--|--|
| <input type="checkbox"/> Family member with heart disease | <input type="checkbox"/> Family member with mental illness (i.e. depression) |
| <input type="checkbox"/> Family member with high cholesterol | <input type="checkbox"/> Family members with alcohol / drug problems |
| <input type="checkbox"/> Family member with diabetes | <input type="checkbox"/> Family medical problems not addressed above |
| <input type="checkbox"/> Has any sudden family member died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

PLEASE SPECIFY WHICH FAMILY MEMBER (Maternal / Paternal): _____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

I have read the information regarding the CIFC Health School Based Health Center, and I give permission for this student to obtain all services offered at the School Based Health Center while he/she is enrolled in school. I understand that services are confidential, except in life-threatening situation or emergency services and accordance with the law. I give permission to the CIFC Health School Based Health Centers and the Danbury Public Schools to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment, and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing. I authorize payments to be made directly to the CIFC Health School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the CIFC Health's privacy policy as per federal law. Unless I choose to withdraw my consent in writing, this authorization for services at the School Based Health Centers will continue for the entire period of time this student is enrolled in Danbury Public Schools.

Yes No I received the HIPAA Notice of Privacy Practices Notice

DATE: _____ SIGNATURE: _____ RELATIONSHIP TO STUDENT: _____