*Registration # _____*

CIFC Health

Connecticut Institute for Communities, Inc. (CIFC)

# 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) | ☐ Male ☐ Female ☐ Other _____ | Grade/Cluster |
|---|---|---|---|
| Street Address (Street, Town, State, ZIP code) | | Student's Cell 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) ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ More than one race ☐ Unreported / Refuse to Report | | In what country was the student born? |
|---|---|---|
| ***Ethnicity:** Hispanic/Latino? ☐YES or ☐ NO | What language(s) does the student speak? (*check all that apply*) ☐ English ☐ Spanish ☐ Portuguese ☐ Other: _____ | Translator needed: ☐ YES or ☐ NO |
| Is the student on the free or reduced lunch program? ☐ YES or ☐ NO | Estimated Family Income $: | # of Family Members: |

| **Medical Care** | | **Dental Care** | |
|---|---|---|---|
| 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 #:** _____

Does the student have **MEDICAID/Husky Insurance:** YES or NO
Medicaid Pending: YES or NO
****Please provide a copy of the insurance card**

**If your child does not have health insurance**
**Please call 1-877-CT-HUSKY**

**Medicaid** #: _____

Child's name on Card: _____

***If NO insurance, contact the SBHC for enrollment Assistance**

Does the student have **Private/Commercial Insurance:** YES or NO
****Please provide a copy of the insurance card**

Name of Insurance Company: _____
Policy Holders Name: _____
Policy Holders Date of Birth: _____
Policy Holders Address: _____
Policy Holders Employer: _____
Relationship to student: _____
Insurance Number for the student: _____
Group number: _____

***Newtown Middle School SBHC (7:30am – 2:30 pm) Phone: (203) 270-6114 Fax: (203) 270-4644***

****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 that apply and explain on the lines below:***

☐ Hospitalization or Surgery
☐ Allergies (food, medication, bees, etc.)
☐ Seasonal / Environmental Allergies
☐ Broken bones, Dislocations
☐ Muscle or Joint Injuries
☐ Neck or Back Injuries
☐ Heart Defects / Murmurs
☐ High Blood Pressure / Cholesterol
☐ Chest Pain during or after exercise
☐ Fainting or Blacking Out
☐ Running / Exercise Problems
☐ Asthma / Breathing Issues
☐ Blood Disorders /Anemia / Sickle Cell
☐ Vision Problems (Contacts / Glasses)
☐ "Mono"
☐ TB or Positive Skin Test
☐ Skin Problems (Eczema, Psoriasis)
☐ Dental Problems (Pain / Bleeding)
☐ Concussions
☐ History of Seizures
☐ Headaches / Migraines
☐ Diabetes/Thyroid/Endocrine
☐ Weight or Eating Issues
☐ Females: Menstrual problems
☐ Stomach Problems
☐ Hearing Problems
☐ 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 that apply and explain on the lines below:***

☐ Mood Disorder / Depression
☐ Anxiety / Panic / OCD
☐ Anger / Other behavioral issues
☐ Academic concerns
☐ Cutting / Self-harm
☐ Learning Disorder / ADD / ADHD / Autism Spectrum
☐ Loss / Divorce / Deportation of family members
☐ Substance use / Vaping
☐ Eating / Significant weight loss or gain
☐ Other unlisted concerns

_____
_____
_____

**Family History:** ***Please check all that apply and explain which family members they apply too on the lines below:***

☐ Family member with heart disease
☐ Family member with high cholesterol
☐ Family member with diabetes
☐ Family member with mental illness (i.e. depression)
☐ Family members with alcohol / drug problems
☐ Family medical problems not addressed above

☐ **Has any sudden family member died of heart problems or sudden death before age 50? ☐ Yes ☐ 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 Newtown 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 Newtown Public Schools.***

**Yes ☐ No ☐ I received the HIPAA Notice of Privacy Practices Notice**

**Date:**_____ **Signature:**_____ **Relationship to student:**_____