



CITY OF STAMFORD  
DEPARTMENT OF HEALTH & SOCIAL SERVICES  
STAMFORD GOVERNMENT CENTER  
888 WASHINGTON BOULEVARD  
P.O. BOX 10152  
STAMFORD, CT 06904-2152

Dear Parent/ Guardian,

The School-Based Health Centers are a joint effort of Family Centers, Inc., the Stamford Health Department and the Stamford Public Schools. There are currently five School-Based Health Centers serving seven schools in Stamford. A dental Clinic in Westhill High School serves children from all Stamford Public Schools. The clinics are in the following locations:

Stamford High School  
Dolan Middle School/Toquam Elementary School  
Cloonan Middle School

Rippowam Middle School/AITE High School  
Westhill High School

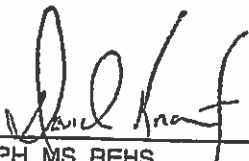
Family Centers Inc., School Based Health Center Services include:

- Assessment of Skin Problems
- Den For Grieving Kids \*\*
- Dental Assessments (including x-rays),  
Treatments  
(Filings, Extractions, Root Canals including  
Anesthesia & Referrals.
- Drug, Alcohol & Tobacco Abuse Counseling &  
Referral
- Immunizations & TB Screening
- Information, Treatment, Referrals for Sexual  
Concerns and Problems
- Laboratory Tests (Strep, TB, Anemia etc.)
- Management of Chronic Conditions (Allergies,  
Asthma, etc.)
- Physical exams
- Preventative Health Education Programs
- Psychiatric Services
- Reaching Independence Through Employment  
(RITE)
- Referrals To & Follow up With Medical  
Specialists
- Individual & Group Counseling
- Nutritional Guidance
- Treatment of Minor Illnesses and Injuries
- Young Parents Program (YPP)

\*\*Additional Permission Required

The State of Connecticut, the United Way and Stamford Public Schools provide funds for the operation of these health centers. As of August 1996, the health centers were required to bill third party insurance companies for services provided in the school-based health centers. Billing of third party insurers will assist in covering the increasing costs of operation the school-based health centers. You or your child will not be charged directly for any services. Students and families without any insurance coverage will not be charged and services will be covered by existing grants. The school-based health centers will not bill parents or students for any co-payments required by insurance, they will not seek payment from you if you have not met your insurance company's deductibles, and will not seek direct payment from you if the claim submitted to an insurance company for services provided is denied by the insurance company. Billing should not have any impact on the premiums you pay.

If you have any questions regarding the school-based health centers please call Dennis Torres, Family Centers, Inc., Director of Healthcare Programs at (203) 977-4848. We encourage you to complete and sign the attached permission form and return it to your child's school.

  
David Knauf, MPH, MS, REHS  
Interim Director of Health

  
James A. Connelly  
Interim Superintendent of Schools



Dear Parent or Guardian:

I invite you to enroll your child in our School Based Health Center!

As parents, we are often running around from place to place, trying to juggle multiple roles around the house and at work. Finding the right balance between normal day-to-day activities and tending to the medical and/or social service needs of your child can be difficult.

This is where your child's School Based Health Center can help. Our mission is to keep your child healthy, happy and in school. Our School Based Health Center is located in your child's school. We operate much like a small doctor's office does. Our Nurse Practitioner works closely with the school nurse and is available during the school day to assist students with basic sick visits, physicals, immunizations and more. We also have a Social Worker at each clinic who is happy to meet with students and their families who may be struggling or dealing with issues. If necessary, we also have a Psychiatrist that cycles through all our clinics.

While we do bill insurance (where applicable) and we request that information in our enrollment form, there are no out of pocket costs for any of our services provided to your child. Regardless of insurance coverage, no student is ever turned away from receiving our professional care. Additionally, your child can access School Based Health Center services even if they have a medical or dental provider in the community. We will coordinate their care with them as you see fit.

Therefore, I encourage you to take a few minutes to fill out the attached enrollment form (don't forget to sign!). This one-time enrollment will allow your child to access School Based Health Center services throughout the remainder of their time as a student in Stamford Public Schools. Even if your child never needs our services, we still encourage enrollment.

Please call me directly if you have any questions and I will be happy to share with you all the good things being done in our School Based Health Centers every day! I can be reached directly at 203-977-5108.

Sincerely;

Dennis Torres, JD, LCSW  
Director of Healthcare Programs

## **Your Information. Your Rights. Our Responsibilities.**

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. An unabridged copy of our Privacy Practices is located at all Family Centers locations, health centers and can also be found on our website [www.familycenters.org](http://www.familycenters.org).

### **SUMMARY**

#### **Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

#### **Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

# STAMFORD SCHOOL-BASED HEALTH CENTERS PERMISSION FORM

Please complete all information requested. Please **USE INK** and **PRINT CLEARLY**.  
You must sign and date the last page of this form in order for your child to receive medical,  
behavioral health and/or dental services from the School-Based Health Centers.  
If a student is 18 or older, he/she can sign his/her own permission form.

Student's Name: \_\_\_\_\_ Sex: Female: \_\_\_\_\_ Male: \_\_\_\_\_  
Last First Middle

Student's Email: \_\_\_\_\_ Student's cell # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Student's Place of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Mother/Father or Guardian Name: \_\_\_\_\_ Day Phone#: \_\_\_\_\_

Parents email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Emergency Contact

Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Cell # \_\_\_\_\_

### Race of Student: (Please check at least one)

Asian \_\_\_\_\_ Black/ African Descent \_\_\_\_\_

Native American \_\_\_\_\_

Native Hawaiian \_\_\_\_\_ Pacific Islander \_\_\_\_\_

Two or More Races \_\_\_\_\_ White \_\_\_\_\_

### Ethnicity of Student: (Please check one)

Hispanic or Latino \_\_\_\_\_

Not Hispanic or Latino \_\_\_\_\_

### Medical Insurance Information – Must be Filled Out Completely:

**INSURANCE WILL BE BILLED FOR SERVICES PROVIDED. YOU ARE NOT RESPONSIBLE FOR ANY COST OR CO-PAY NOT COVERED BY YOUR INSURANCE.**

Medicaid (Husky) # \_\_\_\_\_ Student's Social Security # (for Husky only) \_\_\_\_\_

Private/Commercial Insurance \_\_\_\_\_ (*Please fill out information below*) No Medical Insurance Coverage \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION:

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Home Address: \_\_\_\_\_

Policy Holder's Employer's Name & Address: \_\_\_\_\_

Name of Insurance Company and Address: \_\_\_\_\_

Policy # or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Plan #: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

**Please ATTACH a copy of insurance card (front and back) with this form.**

FOR OFFICE USE ONLY

SBHC Chart #: \_\_\_\_\_

Insurance Updated \_\_\_\_\_

Date Opened (first visit): \_\_\_\_\_

**Dental Insurance Information – Must be Filled Out Completely:**

**INSURANCE WILL BE BILLED FOR SERVICES PROVIDED. YOU ARE NOT RESPONSIBLE FOR ANY COST OR CO-PAY NOT COVERED BY YOUR INSURANCE.**

Medicaid (Husky) # \_\_\_\_\_ Student's Social Security # (for Husky only) \_\_\_\_\_

Private/Commercial Insurance \_\_\_\_\_ *(Please fill out information below)* No Dental Insurance Coverage \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Holder's Employer's Name & Address: \_\_\_\_\_

Name of Insurance Company and Address: \_\_\_\_\_

Policy # or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Plan #: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

**Please ATTACH a copy of insurance card (front and back) with this form.**

Does your child have any: Circle one; if yes, please list

1. Chronic illnesses: No Yes \_\_\_\_\_

2. Disabilities: No Yes \_\_\_\_\_

Is your child taking any medications (circle one) No Yes (Please List) \_\_\_\_\_

Does your child have any allergies to food? (Circle one) No Yes (Please Explain) \_\_\_\_\_

Does your child have any allergies to drugs? (Circle one) No Yes (Please Explain) \_\_\_\_\_

Does your child have any allergies to environmental factors? (Circle one) No Yes (Please Explain) \_\_\_\_\_

Does your child have any allergies to latex? (Circle one) No Yes (Please Explain) \_\_\_\_\_

Does your child have any other allergies? No Yes (Please Explain) \_\_\_\_\_

Has your child ever been hospitalized / had surgery / been injured? No Yes (Please explain) \_\_\_\_\_

**Has your child had any of the following?**

Yes

- \_\_\_ Alcohol/Drug Problems
- \_\_\_ Arthritis
- \_\_\_ Asthma/Reactive Airway
- \_\_\_ Attention Deficit Disorder
- \_\_\_ Blood Disorders (Anemia)
- \_\_\_ Broken Bones
- \_\_\_ Cancer
- \_\_\_ Chicken Pox
- \_\_\_ Concussions
- \_\_\_ Depression/Anxiety
- \_\_\_ Diabetes
- \_\_\_ Ear Infections
- \_\_\_ Fainting
- \_\_\_ Headaches
- \_\_\_ Hearing Problems

Yes

- \_\_\_ Heart Problems
- \_\_\_ Hepatitis/Liver Disease
- \_\_\_ Hernia/Undescended Testicle
- \_\_\_ High Blood Pressure
- \_\_\_ High Cholesterol/Triglycerides
- \_\_\_ Immune Deficiency Disorders
- \_\_\_ Knee Injury
- \_\_\_ Measles
- \_\_\_ Meningitis
- \_\_\_ Menstrual Problems
- \_\_\_ Mental Health Concerns
- \_\_\_ Mononucleosis
- \_\_\_ Mumps
- \_\_\_ Murmur
- \_\_\_ Organ Removal/Transplant

Yes

- \_\_\_ Pneumonia
- \_\_\_ Pregnancy
- \_\_\_ Prosthetics
- \_\_\_ Rheumatic Heart Disease
- \_\_\_ Scoliosis
- \_\_\_ Seizures
- \_\_\_ Sickle Cell Trait or Disease
- \_\_\_ Skin Disorders
- \_\_\_ Sleeping Problems
- \_\_\_ Stomach/Bowel Problems
- \_\_\_ Thyroid Problems
- \_\_\_ Tuberculosis
- \_\_\_ Urinary Tract Infection
- \_\_\_ Vision Problems
- \_\_\_ Weight or Eating Problems

If Yes, please specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please list any concerns you have regarding your child's health:

**Family Health History:**

Please check below if any of your child's relatives (i.e. parents, brothers/sisters, aunts, uncles, grandparents) have/had any of the following illnesses and note which relative on the lines below:

ILLNESS	Relative	ILLNESS	Relative
<input type="checkbox"/> Alcohol/Drug Problems	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Blood Disorders including Anemia	_____	<input type="checkbox"/> Infections (TB, HIV, AIDS)	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Liver/Kidney Problems	_____
<input type="checkbox"/> Death under the age of 50	_____	<input type="checkbox"/> Mental Illness, Emotional Problem	_____
<input type="checkbox"/> Diabetes, Endocrine Disorder	_____	<input type="checkbox"/> Respiratory Problems including Asthma	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Sickle Cell Trait or Disease	_____
<input type="checkbox"/> Heart problem, Vascular Disease/Stroke	_____	<input type="checkbox"/> Seizures	_____

Does your child get free or reduced priced lunch?  Yes  No

Who lives with Student?  Mother  Father  (#of )Siblings  other (explain) Total Number of people at home: \_\_\_\_\_

Female Head of Household?  Yes  No Annual Household Income: \_\_\_\_\_

Where do you get your child's medical care? (Check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Community Health Center  | <input type="checkbox"/> Military Clinic            | <input type="checkbox"/> Urgent Care Clinic |
| <input type="checkbox"/> Emergency Room           | <input type="checkbox"/> No Regular Source          | <input type="checkbox"/> Unknown            |
| <input type="checkbox"/> Health Department Clinic | <input type="checkbox"/> Private Doctor             | <input type="checkbox"/> Walk In Clinic     |
| <input type="checkbox"/> Hospital Clinic          | <input type="checkbox"/> School Based Health Center | <input type="checkbox"/> Other Type: _____  |

Who is your child's Doctor / Clinic? \_\_\_\_\_ Phone # \_\_\_\_\_ Don't have one \_\_\_\_\_

Name of any Specialists treating your child \_\_\_\_\_ Phone # \_\_\_\_\_ Don't have one \_\_\_\_\_

Who is your child's Dentist? \_\_\_\_\_ Phone # \_\_\_\_\_ Don't have one \_\_\_\_\_

When was your child's last dental visit? \_\_\_\_\_

Is an orthodontist following your child?  Name & Phone # \_\_\_\_\_

Do you have any concerns about your child's teeth?

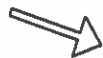
Has your child ever had anesthesia (Novocain, Laughing gas) for dental work?  No  Yes

Any problems with anesthesia?

Does your child take medication before seeing the dentist?  No  Yes Please Explain: \_\_\_\_\_

**Please Remember to Sign This Form in INK**

My signature below indicates that I have read the foregoing regarding the services of the School Based Health Centers (SBHC) and have received the Privacy Notice (attached). I give permission for the above named student to obtain services offered at the SBHC while he/she is in school. I give permission for the exchange of relevant health and safety information between the SBHC and appropriate school staff involved in the overall care of the named student within the confines and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the attached Privacy Notice and The Family Education Rights and Privacy Act (FERPA) (20 U.S.C. subsection 1232g; 34 CFR Part 99). The goal of this process will be to assist in maintaining health and safety in schools and to coordinate my child's care. Furthermore, I give permission to the SBHC to release information regarding treatment and/or services (medical, dental and/or behavioral health services) to the named insurance providers for the purpose of billing. I authorize payments to be made directly to Family Centers Inc. for services provided.



Parent/Guardian/Student (only if 18 or older)

Date