STUDENT INFORMATION

Full Legal Name: *(of person who will receive services)* _____ DOB: _____

Street Address/Apt. #: _____ City: _____ Zip: _____

Sex: Male Female Ethnicity (check box): Hispanic Non-Hispanic Student's Primary Language: _____

Race (check box): Unknown American Indian Pacific Island Alaskan Native Black Asian White Other

Does the student qualify for free/reduced lunch? YES NO School Student Attends: _____ Grade: _____

INSURANCE INFORMATION

No Insurance

Medical Insurance(s): _____ Medicaid ID# _____

Insurance Address: _____ Insurance Phone # (on back of card) _____

Policy Holder Name: _____ Policy Holder DOB: _____

Private Insurance ID/Policy #: _____ Group Number: _____

Insurance Address: _____ Insurance Phone # (on back of card) _____

Policy Holder Name: _____ Policy Holder DOB: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Student: _____ DOB: _____

Street Address/Apt. # (if different from above): _____ City: _____ ZIP: _____

I agree that voicemail messages can be left for me on: Home Phone Cell Phone Work Phone

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Email Address: _____

Student's Cell Phone: _____ Student's Email Address: _____

Student's Primary Care Provider's Name: _____ Phone #: _____

Student's Dentist's Name: _____ Phone #: _____ Has your child seen this dentist/group for 1+ year(s)? ☐YES ☐NO

SECOND EMERGENCY CONTACT

Name: _____ Relationship to Student: _____ Phone Number: _____

By signing below, I understand and acknowledge I have read and understand this consent:

I give permission for my child/self to obtain routine health services at the School-Based Health Center.

All insurances will be billed at time of visit. No out-of-pocket costs for medical services rendered in school. No one will be refused services due to the inability to pay.

Annual Wellness Screening visits may be completed for healthy lifestyle assessment. Parents/guardians will be notified before screening visits. Please check box to opt OUT ☐.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of any medical or behavioral health information necessary to process my claim. I also authorize payment of health benefits to Child & Family Agency for services provided.

CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand and acknowledge that I have read and understand this consent and I have received CFA's Notice of Privacy Practices currently in effect. I understand that information regarding how CFA will use and disclose my information can be found in CFA's Notice of Privacy Practices. I understand my consent is effective for as long as CFA maintains my protected health information.

AUTHORIZATION FOR EXCHANGE OF HEALTH AND EDUCATION INFORMATION

I give permission to allow Child & Family Agency (CFA) to exchange as needed information with my child's medical provider, school nurse, and key school personnel in order to effectively care for my child. I understand that SBHC medical and mental health providers may communicate with each other about my child's care if indicated.

I also certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the patient's health. I will notify the School-Based Health Center of any changes to medical information.

Signature of Parent/Legal Guardian/Personal Representative (or Student if over 18 years old): _____

Print Name: _____ **Date:** _____

By signing above, I understand that this authorization is valid until I revoke this authorization. *I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my child will continue to be enrolled in a CFA SBHC as long as child is enrolled in school that has a CFA SBHC, although yearly updates will be requested. I recognize that health records, if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Education Rights and Privacy Act.*

Please also complete reverse side →

You can also register online in English or Spanish! Visit: https://www.childandfamilyagency.org/schoolreg

Patient (Student) FULL NAME: _____

MEDICAL HISTORY			Date of Last Physical Exam: ___/___/___
Does the patient have any medical conditions?	☐YES	☐NO	Explain:
Does the patient take any medications (including inhalers or vitamins)?	☐YES	☐NO	List:
Has the patient had any serious injuries (including a head injury)?	☐YES	☐NO	Explain:
Does the patient have a birth or heart defect?	☐YES	☐NO	Explain:
Has the patient ever been hospitalized overnight?	☐YES	☐NO	Explain:
Has the patient had any surgery in the past?	☐YES	☐NO	Explain:
Does the patient have any problems with sleeping and/or snoring?	☐YES	☐NO	Explain:
Has the patient had a dental cleaning within the past 6-12 months?	☐YES	☐NO	Approximate date of last dental cleaning (MM/YY) _____
Does anyone smoke in the home?	☐YES	☐NO	
Does the patient smoke, use e- cigarettes, or chew tobacco?	☐YES	☐NO	
Does the patient get 60 min of exercise at least 3 times a week?	☐YES	☐NO	
Are you concerned with the amount of time your child spends on social media, T.V., video games, computer, or phone?	☐YES	☐NO	Explain:
Any other concerns about your child's health or weight?	☐YES	☐NO	Explain:

PATIENT HISTORY of any of the following:			FAMILY HISTORY – please note relationship to patient:		
Anemia/Blood disorders	☐YES	☐NO	Anemia./blood disorders	☐YES	☐NO
Asthma	☐YES	☐NO	ADD/ADHD	☐YES	☐NO
Autism	☐YES	☐NO	Asthma	☐YES	☐NO
Birth defects (heart, lung, brain, etc.)	☐YES	☐NO	Cancer/leukemia	☐YES	☐NO
Cancer/Leukemia	☐YES	☐NO	Diabetes/ Endocrine/ Gland Disease /Autoimmune	☐YES	☐NO
Diabetes/ Endocrine/ Gland Disease /Autoimmune	☐YES	☐NO	Headaches/ Migraines	☐YES	☐NO
Digestive issues/Diarrhea/Constipation	☐YES	☐NO	Overweight/ Obesity	☐YES	☐NO
Headaches/Migraines	☐YES	☐NO	Skin problem (acne, eczema, etc.)	☐YES	☐NO
Learning/Developmental Issues	☐YES	☐NO	Mental Health Issues	☐YES	☐NO
Seasonal Allergies	☐YES	☐NO	Seizures	☐YES	☐NO
Heart murmur	☐YES	☐NO	Heart disease	☐YES	☐NO
Skin problems (eczema, acne, etc.)	☐YES	☐NO	Hypertension	☐YES	☐NO
Seizures	☐YES	☐NO	Substance use	☐YES	☐NO
Overweight or Obesity	☐YES	☐NO	Tobacco use	☐YES	☐NO
COVID 19	☐YES	☐NO	Other:		

ALLERGIES			
Any foods? (including lactose intolerance)	☐YES	☐NO	Comment:
Any medications? (including over the counter or antibiotics)	☐YES	☐NO	Comment:
Does the patient have an Epi-Pen (or similar prescription) at school?	☐YES	☐NO	Comment:
Other:			

BEHAVIORAL HEALTH

Has the patient ever had or currently receiving counseling services? ☐YES ☐NO **If YES**, ☐With CFA ☐Other: when/with whom?

Are you interested in receiving information about mental health counseling for your child at the SBHC? ☐YES ☐NO

Has the patient ever had any of the following:

Family changes	☐YES	☐NO	Anger issues	☐YES	☐NO
School issues	☐YES	☐NO	ADHD/Attention issues	☐YES	☐NO
Social/peer stresses	☐YES	☐NO	Depression	☐YES	☐NO
Anxiety/Panic Attacks	☐YES	☐NO	Truancy/school avoidance	☐YES	☐NO
Learning disabilities	☐YES	☐NO	Recent loss/crisis	☐YES	☐NO